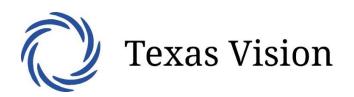


**PATIENT INFORMATION:** Patient's Name: Unit# City Number Street State Zip Code **Mailing Address:** Home Telephone: Social Security Number: Date of Birth: Marital Status: Spouse Name: ☐ Male ☐ Female [ ] Married [ ] Single [ ] Divorced Minor Child Guarantor's Name: Minor Child Guarantor's Address (if different than above): **Emergency Contact Name:** Work Phone: Cell Phone: Patient's E-mail Address: May we use this E-mail address to contact you? YES NO How Did you hear about Texas Vision? INSURANCE INFORMATION: Policy/Subscriber ID# **Primary Insurance Company:** Group Number: Who provides Insurance: Date of Birth: Name ☐ Patient ☐ Spouse ☐ Parent ☐ Other Group Number: Policy/Subscriber ID# **Secondary Insurance Company:** Who provides Insurance Name Date of Birth: ☐ Patient ☐ Spouse ☐ Parent ☐ Other **PATIENT CONSENT:** IF INSURED: The undersigned hereby authorizes the release of any information regarding all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each claim to be submitted by myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed that particular claim. IF NOT INSURED: I understand that Texas Vision is accepting me as a private pay patient. I will be responsible for paying for all services that I receive from this Practice. The doctor's office will not file a claim to any insurance company, including Medicaid for services By signing below, I affirm that I have reviewed a copy of the Office Policies. I have read and understand the policies. Patient or Legal Guardian Signature: Date:



Patient Account # (for of)	ent Account # (for office use): Today's Date:									
Patient's Name: (Please Print)					DOB:					
Allergies:										
Current & Prior Medica	al History:				When D	iagnose	d:			
Use of Alcohol:				Use of To	bacco:					
[ ] Never [ ] Rarely	[ ] Moderately [ ] Dail	ydrin	nks/day	[] Nevei	[ ] Quit			_ date [ ] Da	ily	packs/day
I have had the Inf	luenza Vaccine:	I have h	nad the Pne	umococcal	Vaccine:			History of Su	ıbstance Abu	se:
[ ] Yes	[ ] No		[ ] Yes [ ]		[ ] No			[ ] Yes [ ] No		
Currently Pregnant/Trying to Conceive [ ] Currently Breast Feeding [ ]		Occupation:					Do you drive?			
		Retired [ ] Student [ ] No						[ ] Yes [ ] No		
Recently Gav	ve Birth [ ]	Rearea	[ ] Student	. [ ] 1.00 //	, ming[]					
Medications	Dosage	How Ofter	n	Medicati	ons		Do	osage	How O	ften
1				9						
2				10						
3				11						
4				12						
5				13						
6				14						
7				15						
8				16						
Pharmacy Name:		City:			State:	Telepho	one:		FAX:	
Referring Doctor:		I	City:			1		Telephone:		
			•					-		
Primary Care Doctor:			City:					Telephone:		
Have you seen one of	our doctors before:	[ ] Yes	[ ] No	Appro	oximate D	ate:				



### PAYMENT POLICY

Thank you for choosing Texas Vision as your care provider. Some of our patients have concerns regarding insurance versus patient responsibility for payment for services rendered. We have developed the following payment policies:

<u>Insurance</u> - We will file claims for all applicable visits and procedures. You are responsible for payment if any copays, deductibles, co-insurance and all non-covered services. The insurance contract is between the patient and the insurance company. The ultimate responsibility for payment rest with the patient.

<u>Referral and Pre-Authorizations</u> — You are required to 1) know whether or not your insurance requires referral for medical and/or surgical treatment and 2) obtain that referral before you are scheduled to see the doctor. Our office will assist you in determining if we are participating or non-participating providers. However, this is not a guarantee of coverage. Referrals typically have an expiration date and a limited number of visits; it is your responsibility to monitor your referral status.

<u>No Insurance</u> – Payment in full is due when service is rendered. We understand that individual situations may vary and we will discuss other payment arrangements as needed.

<u>Returned Checks</u> – You will be charged \$30 for each returned check. You will be asked to provide payment by cash or credit card for the total cost of the check and the \$30 fee.

<u>Non-Covered Services</u> – We will make every effort to inform you if we believe a service may not be covered by your insurance company. In our professional judgement, these services are needed to render high quality medical care even though they may not be covered by insurance. You will be expected to pay for such services, even if your insurance company denies payment. <u>Texas Vision is not a provider for separate vision plans.</u> We will file to your medical insurance if appropriate.

<u>Appointment Cancellations and No-Shows</u> – If you need to cancel or reschedule your appointment, please give our office at least 24 hour notice.

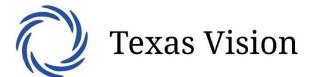
Г	Patient or Legal Guardian Signature:	Date:
L		

### REFRACTION FEE POLICY

The refraction fee is \$30. Refraction is the process of determining your prescription. The refraction is also necessary in order to rule out certain eye problems. The refraction test occurs when your doctor shows you a variety of corrective lenses and asks you to say which lens makes the images being viewed better or worse. A refraction is an essential part of a complete and comprehensive eye exam but it is NOT a covered service by most medical insurance plans including Medicare. Please be aware that if this service is performed during your examination, a refraction charge of \$30 will be collected today in addition to your copayment. **\*You have 90 days from the date of prescription to follow up for any rechecks. After 90 days an additional \$30 will be require for any rechecks\*** 

By signing below I affirms that I have read and understand that the refraction is a non-covered service. I understand I will only be charged this fee when a refraction process is done during my examination and that this fee is due at the time of service.

Patient or Legal Guardian Signature:	Date:



### **Authorization for Release of Information**

I, the undersigned, hereby authorize the below named doctor to release my medical information.

Physician's Name:	Name of Practice:
Address: Number Street Unit #	City State Zip Code
Phone Number:	Fax Number:
<b>FO:</b> If records are to be sent to Texas Vision, please che	ck this box  and continue to "The Reason"
Physician's Name:	Name of Practice:
Address: Number Street Unit#	City State Zip Code
Phone Number:	Fax Number:
The Reason For Request:	
☐ Continuity of Care ☐ New Doctor ☐ Other	r: (specify)
I understand that my records are confidential and cannot be opposited by law.	lisclosed without written authorization, except as otherwise
This authorization is valid for six (6) months and may be rev	oked by the patient, orally or in writing, at any time prior to
the six month period.  The information released should include all histories, physical	al exams progress notes lab and Xray reports mental
health records, alcohol/substance abuse records, HIV records	
otherwise specified below.	
Your prompt reply to my request is greatly appreciated.	
According to state and Federal Law, this form must be signed information exists in your chart. Texas Vision charges a fee	÷
Patinet Name: (Please Print)	Date of Birth:
Patient Signature:	Date:
Acknowledgement of Re	view of Notice of Privacy Practices

My signature above indicates that I have reviewed this office's Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at my request.

FROM:

# **PATIENT AUTHORIZATION FORM**

## **Authorization to Release Information to Family Members**

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. I DO NOT authorize Vision Center of Texas (Texas Vision) to release my records and any information requested to any individuals. ☐ I authorize Vision Center of Texas (Texas Vision) to release my records and any information requested to the following individuals. 1. \_\_\_\_\_ Relation to Patient: Relation to Patient: Relation to Patient: **Disclose Medical/Appointment Information:** (Please check all that apply or ALL for all items listed) ALL **Appointment Information** Surgical Procedure Information External Lab Results & Imaging Medical History Financial & Insurance Information Explanation of diagnosis and/or procedure Patient Name (PLEASE PRINT) Date of Birth

Date

Patient Signature

6/27/2022