



PATIENT REGISTRATION AND CONSENT FORM

Welcome to our office! If you should need assistance in completing this form, please ask a staff member for help.

PATIENT INFORMATION

Last Name: First Name: Middle Initial: Preferred Name (if applicable): Status: Child Single Married Widowed Separated Divorced Street Address: Apt# City: State: Zip: Date of Birth: Sex: Male Female Social Security #: Race: American Indian /Native Alaskan Asian Black /African American Hispanic /Latino Native Hawaiian /Pacific Islander White Other CellPhone:( ) Home Phone: ( ) Work Phone:( ) Email Address: Occupation: Employer (or School if student): How were you referred to us? Family/Friend Physician Internet Insurance Newspaper Phone Book Radio Walk-In Other If personally referred, whom may we thank for the referral?

GUARANTOR INFORMATION (If patient is a Minor or Dependent)

Last Name: First Name: Middle Initial: Street Address: Apt# City: State: Zip: Date of Birth: Sex: Male Female Social Security #: CellPhone:( ) Home Phone: ( ) Work Phone:( ) Relationship to Patient: Email Address:

COMMUNICATION PREFERENCE

In order for our office to better communicate with you, please indicate your preferences below: What is your primary phone contact? Cell Phone Home Phone Work Phone May we send you text messages (i.e. glasses ready for pick-up, appt. reminders)? Yes No If yes, please list your cellular provider May we communicate with you by email? Yes No

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We are required by law to maintain the privacy of your health information and make every effort to inform you of your rights. The Notice contains a section describing your rights under the law related to your personal health information. You have a right to review our Notice of Privacy Practices before signing this consent. By signing below, I acknowledge that I have reviewed or had explained to me TSO Woodlands' Notice of Privacy Practices and agree to continue my care with TSO Woodlands under said terms.

Patient or Guarantor Signature

Date

INSURANCE AUTHORIZATION AND FINANCIAL RESPONSIBILITY DISCLOSURE

My signature below authorizes Linh T. Yee-Young, O.D., P.A. dba TSO Woodlands to release any medical information necessary to process my or my dependent's insurance claim. I authorize any benefits due be paid directly to TSO Woodlands. Your insurance company only provides our office an "estimate" of covered benefits prior to receiving any services or materials from us. This "estimate" is not a guarantee of benefits. I understand that I may be required to pay a deductible, co-pay, co-insurance, or any balance not covered by my insurance plan. In the event that my insurance does not fully pay for services and/or materials rendered to me, I agree to be responsible for payment of all balances on my or my dependent's behalf. I understand that all fees for professional services shall be paid at time of service and are NON-REFUNDABLE. Any returned check will incur a \$30 fee. I am also aware that prescription eyeglasses are a custom order therefore, any cancellation after 24 hours of placing the order will be NON-REFUNDABLE. I certify that I have read and understand the above information to the best of my knowledge.

Patient or Guarantor Signature

Date