



**PATIENT GENERAL CONSENT & FINANCIAL RESPONSIBILITY FORM**

PATIENT'S LEGAL NAME: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

NEW PATIENT     RETURNING

**INDIVIDUAL RESPONSIBLE FOR PAYMENT OF UNPAID BALANCES**

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**FAMILY MEMBER OR OTHER PERSONS WE MAY INFORM ABOUT YOUR MEDICAL CONDITION/DIAGNOSIS:**

NAME:	RELATIONSHIP:	PHONE NUMBER:
NAME:	RELATIONSHIP:	PHONE NUMBER:

**PATIENT'S BILLING INFORMATION**

<b>STREET ADDRESS</b>		
<b>CITY, STATE, ZIP</b>		
<b>HOME NUMBER</b>		MAY WE SEND YOU TEXT MESSAGES FOR APPT UPDATES? (NO SPAM) YES ____ NO ____
<b>MOBILE NUMBER</b>		
<b>EMAIL</b>		
MAY WE SEND YOU EMAILS WITH PRACTICE ANNOUNCEMENTS? YES ____ NO ____		
<b>EMPLOYER</b>		
<b>SOCIAL SECURITY NUMBER</b>		
Can we leave confidential messages such as appointment reminders on the home, mobile, or email provided? YES ___NO___SPECIFIC INSTRUCTIONS:		

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE RECEIPT**  
I HAVE RECEIVED A COPY OF TSO NEW BRAUNFELS' NOTICE OF PRIVACY PRACTICES WITH AN EFFECTIVE DATE OF MAY 13, 2020.

<b>PATIENT / PATIENT REPRESENTATIVE (PRINTED NAME)</b>	<b>PATIENT / PATIENT REPRESENTATIVE SIGNATURE</b>



TEXAS STATE OPTICAL

Since 1936

<b>VISION PLAN NAME</b>	<b>MEMBER/SUBSCRIBER ID NUMBER</b>
<b>MEDICAL PLAN NAME</b>	<b>MEMBER/SUBSCRIBER ID NUMBER</b>

**PRIMARY INSURANCE HOLDER'S INFORMATION**

<b>NAME</b>	
<b>DATE OF BIRTH</b>	
<b>STREET ADDRESS</b>	
<b>CITY, STATE, ZIP</b>	
<b>PHONE NUMBER</b>	
<b>EMPLOYER</b>	
<b>SOCIAL SECURITY NUMBER</b>	

\*ALL PATIENT INFORMATION IS STRICTLY CONFIDENTIAL. YOUR INFORMATION IS NEVER SHARED.

**PRIMARY CARE PHYSICIAN NAME:** \_\_\_\_\_

**PRACTICE NAME:** \_\_\_\_\_

PLEASE INITIAL:

SINCE OUR LAB BEGINS PROCESSING EACH ORDER FOR GLASSES IMMEDIATELY, WE ARE UNABLE TO MAKE ANY CANCELLATIONS AFTER THE CLOSE OF THE CURRENT BUSINESS DAY THAT THE ORDER IS PLACED. LENSES ARE CUSTOM-MADE AND ARE NON-REFUNDABLE.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE BENEFITS (CO-PAYS, WHAT IS/IS NOT COVERED, ETC), PLEASE ASK PRIOR TO SEEING THE DOCTOR AND WE WILL ASSIST YOU THE BEST WE CAN. ANY APPLICABLE CO-PAYS AND PAYMENT FOR ITEMS NOT COVERED BY YOUR INSURANCE MUST BE COLLECTED AT THE END OF YOUR VISIT.

I UNDERSTAND THAT FOR A CONTACT LENS EVALUATION (ACCOMPANIES EVERY CONTACT LENS EXAM BY TEXAS LAW) THE EVALUATION FEE VARIES UPON DIAGNOSIS OF PRESCRIPTION.

**IN THE EVENT THAT THE SPONSOR OF YOUR INSURANCE PLAN DETERMINES THAT YOU ARE NOT ELIGIBLE AT THE TIME OF SERVICE OR MAKES A DETERMINATION THAT YOU ARE ELIGIBLE FOR A REDUCED LEVEL OF COVERAGE, BY SIGNING THIS AGREEMENT YOU AGREE TO BE FINANCIALLY RESPONSIBLE FOR ANY AND ALL OF THE CHARGES INCURRED BY YOURSELF AND THE PLAN SPONSOR.**

<b>PATIENT / PATIENT REPRESENTATIVE (PRINTED NAME)</b>	<b>PATIENT / PATIENT REPRESENTATIVE SIGNATURE</b>