Welcome to the Eye Doctor's Office

Patients Information

Legal Name: _____
First M.I. Last

Circle one: I am: Dr Mr Mrs Ms Miss Jr Sr I II III

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____

Work Phone: (_____)_____-_____

Cell Phone: (_____)_____-_____

Circle one of the following that applies to the patient:

I am employed: Full Time Part Time Self Employed Retired
Homemaker currently not employed

Employer: _____

Occupation:_____

Drivers License # _____State_____Exp_____

Nickname: (Please call me): _____

Circle one: I am: Married Single Widowed Domestic Partner
If Student Circle one: Full Time Student Part Time Student

Date of Birth: ____/____/____ Age: _____ Sex: M or F

Social Security Number: _____/_____/_____

Your Email is only used for in office professional purposes only, such as; recall, confirming appointments & for our contact lens patients, passwords for ordering contact lenses on online. *It will never be shared with any outside persons or sources*.

Home Email: _____

Alternate Email:_____

For New Patients

Whom may we thank for referring you?

_____

Spouse or Parent Information (If applicable)

Employee Name: _____

Relationship to Patient: _____ DOB: ____/____/____

Circle One: I am employed F/T P/T Self Employed Retired Not Employed

Employer: _____

Occupation: _____

Work Phone: (_____)_____-_____Ext_____

Drivers License # _____ State _____Exp_____

Medical/Health Insurance Card Information

This office is a medical facility. Your medical insurance may often times cover advanced testing and treatment of the eyes. Diseases of the body can show up in the eyes. If the doctor determines the need for additional medical testing or treatment, the following information will help us file your claim.

Employee Name:_____ DOB___/___/___ Sex M or F

Company/Employer Name:_____

Relationship to Patient: Self Spouse Child F/T Student Other

Circle One: I am employed F/T P/T Self Employed Retired Not Employed

Insured's ID# _____ Group#_____

SS#_____Medical Plan Name:_____Vision Plan Name_____

Acknowledgment of Notice of Privacy Practices

The Federal Law requires that we make every effort to inform you, the patient, of your right related to your personal health information.
Please check only one below

___ **Yes**, **I have** read or had explained to me by this office the NPP & I wish to continue my care with The Eye Doctor's Office under said terms.

___ **No**, **I have not** read this office's NPP but, I was given the opportunity to read it upfront and declined. I wish to continue my care with The Eye Doctor's Office under the terms.

___ The NPP **could not be read** due to the emergent nature of the care or other reasons described below.

Comments:_____

Release of Health Information to Family, Friends and Others

Please check only one below

___ **Yes, I authorize** all persons listed below the ability to receive materials in my absence and/or information on my behalf.

Name:_____Relationship_____Date_____

Name:_____Relationship_____Date_____

___ **No, I Do Not authorize** any persons the ability to receive materials or information on my behalf. I choose to come myself.

Financial Assignment & Release (Signature Required)

* I, the undersigned, assign directly to American Eye Care Centers, Inc. dba: The Eye Doctor's Office, Inc. and/or Dr. Bob Consor all insurance benefits, if any, otherwise payable by me or to me for services rendered.

* I understand that I am financially responsible today for all fees. I also agree that I am financially responsible to pay any and all fees for services and materials not collected in full at the date of service or should my insurance or vision plan deny payment for services or materials rendered.

* I further understand that after 60 days from the date my services or claim is filed I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier caused by; unmet deductibles, non covered materials or professional services, my negligence in fulfilling any paperwork, providing any required information requested of me by my insurance carrier or uncollected fees on service day.

* If I fail to reimburse said fees in a timely manner with the above stated office and should the need arise, I agree to pay any and all collection fees, court costs and attorney fees.

*** If you do not inform us you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists.**

*** I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered.**

*** I agree this office with NO EXCEPTIONS will not back file claims, post authorize claims, or refund fees after services are rendered due to lack of notification of vision or medical benefits.**

X_____ _____/_____/_____
Patient or Responsible Party Signature Date Signed

_____
Relationship to Patient

The Contact lens Examination: Do you currently wear contacts? **Yes** **No** (*If yes please keep reading)*
Texas State Law requires that contact lens wearers have a contact lens examination every year in order to renew their prescription or buy new lenses. The contact lens exam **is not** part of the comprehensive eye health or refractive vision test examinations. Contact lens patients require additional testing, time, measuring and monitoring to evaluate the design and fit of their current lenses, the health of the eye as it relates to contacts or in the case of a new wearer, their suitability to wear contacts.
The contact lens fee varies with complexity of the lens design and diagnostic fitting time. **Insurance or vision benefit plans may contribute an allowance.**

I understand that there is a separate contact lens examination fee and agree to its terms and conditions of the contact lens examination.

X_____ _____/_____/_____
Patient