TSO Texas State Optical
Since 1936

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

STREET ADDRESS		
CITY, STATE, ZIP		
HOME NUMBER		MAY WE SEND YOU TEXT MESSAGES FOR APPT UPDATES? (NO SPAM) YES _____ NO _____
MOBILE NUMBER		
EMAIL		
MAY WE SEND YOU EMAILS WITH PRACTICE ANNOUNCEMENTS? YES _____ NO _____		
EMPLOYER		
SOCIAL SECURITY NUMBER		
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 SEGUIN'S NOTICE OF PRIVACY PRACTICES WITH AN EFFECTIVE DATE OF JANUARY 31, 2020.*	
PATIENT / PATIENT REPRESENTATIVE (PRINTED NAME)	**PATIENT / PATIENT REPRESENTATIVE SIGNATURE**

INSURANCE INFORMATION ON OTHER SIDE →

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VISION PLAN NAME	MEMBER/SUBSCRIBER ID NUMBER
MEDICAL PLAN NAME	MEMBER/SUBSCRIBER ID NUMBER

PRIMARY INSURANCE HOLDER'S INFORMATION

NAME	
DATE OF BIRTH	
STREET ADDRESS	
CITY, STATE, ZIP	
PHONE NUMBER	
EMPLOYER	
SOCIAL SECURITY NUMBER	

*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.	
PATIENT / PATIENT REPRESENTATIVE (PRINTED NAME)	**PATIENT / PATIENT REPRESENTATIVE SIGNATURE**