Phone: (409) Fax: (409)

PATIENT INFORMATION

Must be same as on insurance card.

Patient ______ LAST ______ FIRST ______ MIDDLE ☐ Jr ☐ Sr ☐ III SUFFIX ______ SSN#

Address Mailing ______ STREET ______ APT# ______ CITY ______ STATE ______ ZIP ______ COUNTRY IF OTHER THAN U.S.

Address Physical (IF DIFFERENT) ______

Home Ph # ______

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED
MARITAL STATUS

Work Ph # ______

☐ FULL ☐ PART ☐ NOT ☐ SELF ☐ MILITARY ☐ RETIRED EMPLOYMENT ☐ FULL TIME ☐ PART TIME ☐ NOT A STUDENT STUDENT

Cell Ph # ______

Sex ☐ M ☐ F Birthdate ______

Primary Care Physician (PCP) ______ LAST ______ FIRST ______ M.

Employer ______

Email ______

PHONE # ______ FAX# ______ EMAIL ______

(The American Recovery & Reinvestment Act requires your provider to offer your clinical information and an active medication list via email which will be beneficial to your overall health.)

MEDICAL / VISION INSURANCE

Insurance ☐ Medicare ☐ Medicare Replacement ☐ Other ______

Insurance through employer ☐ Yes ☐ No Medicaid ☐ Yes ☐ No

Name of Employer ______

Primary Medical Ins. ______

Secondary Medical Ins ______

Vision ONLY Plans ☐ VSP ☐ VBA ☐ Spectera ☐ Other ______

(Be advised it is the patient's responsibility to provide all INS information and give notice of any changes. This includes any time you are using your Vision Only Plan.)

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name ______ DOB

SSN# ______

Mailing Address (ONLY IF DIFFERENT) ______

Phone # ______ Cell# ______

Relationship to Pt. ☐ Spouse ☐ Parent ☐ Other

EMERGENCY CONTACT (OTHER THAN PERSON LIVING WITH YOU)

Name ______

Phone # ______ Cell# ______

Email: ______

Relationship to Pt. ☐ Spouse ☐ Parent ☐ Other

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have reviewed this office's Notice of Privacy Practices, which explains how medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

***List the names of any family members or friends that you give permission for us to release personal information to. This may consist of, but not limited to information about appointments, medication, doctor visits, contact lenses & balances.

______

______

WRITTEN FINANCIAL POLICY

Be advised co-payments, deductibles, and non-covered items are due at the time of service. For your convenience we accept cash, check, Visa, MasterCard, American Express, Discover Card, and Care Credit Finance 0-12% Interest Payment Option. Please speak with an account specialist for additionl information.

DATA ENTRY BY: INITIAL PRINT ______ PATIENT SIGNATURE

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______ and assign directly to SETX Glaucoma Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize SETX. Glaucoma Center to *release all information* necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______
RESPONSIBLE PARTY SIGNATURE

______
RELATIONSHIP ______ DATE

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to SETX Glaucoma Center for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______
BENEFICIARY SIGNATURE ______ DATE

CONDITIONS OF WAIVER

I have been notified by my physicians office that in the event that any charges incurred to my account resulted in non-payment from my insurance company for any of the reasons listed below, I am personally, and fully responsible for any and all payment.

1. If physician is not a participant on your plan, services may not be covered.
2. In the event this procedure is not a covered procedure by you insurance plan.
3. In the event a referral from your primary care physician is required and was not procured, and payment is not received from your insurance plan.

I agree to comply with this waiver.

______
BENEFICIARY SIGNATURE ______ DATE