Date:______________ Doctor:__________________________ Chart #:_______________________

Welcome to Houston Eye Associates. So that we can most effectively meet your needs, please complete all the information below.

HOW DID YOU LEARN ABOUT HOUSTON EYE ASSOCIATES?

Referral was by:

Please provide their name & address so we can thank them:

Physician ______ ____
Name

Optometrist ______ ____
Address Phone

Patient ______ ____
City State Zip

Other ______

PATIENT INFORMATION

Mr.___ Mrs.___ Other ___

Name ____
First Middle Last

Address ____
Street City State Zip

Home Phone ________________ Work Phone ________________ Cell Phone ________________

Soc Sec # ________________ Date of Birth _____ / _____ / _______ Sex Male /Female

Marital Status ___ Single ___ Married___ Divorced ___ Widowed ________________

Employer / Address ________________________________ Phone ________________

Family doctor Name/Address ________________________________ Phone ________________

E-mail address:____

In the future may we confidentially communicate with you through this email address? __Y __ N

PARENT / GUARDIAN INFORMATION (if patient is a MINOR)

Parent / Guardian's Name____
First Middle Last

Address ____
Street City State Zip

Home Phone ________________ Work Phone ________________ Cell Phone ________________

Soc Sec # ________________ DOB __________ Relationship to Patient:Child _____ Other_____

Employer ____

Other Parent / Guardian's Name ____
First Middle Last

Home Phone ________________ Work Phone________________ Cell Phone________________

Employer ____

RESPONSIBLE PARTY (if different from above)

Contact Person____
First Middle Last

Address____
Street City State Zip

Employer/Company/Agency Name ________________________ Phone ________________

See page on back

Houston Eye Associates

Notice of Payment Policies and Procedures

PAYMENT POLICY: It is customary to pay for professional services when rendered. For your convenience we accept major credit cards, checks or cash.

INSURANCE: Please read and sign below if you have insurance with: Medicare, Medicaid, an HMO/PPO/POS or State Agency or Worker's Comp, and the Physician is contracted with your carrier. Present your insurance card along with any required referrals/authorizations to the Receptionist/Registrar.

MEDICAL / SURGICAL BENEFITS ASSIGNMENT AND RELEASE OF MEDICAL BENEFITS INFORMATION AGREEMENT: I request payment of my authorized insurance benefits be made for charges on my behalf to Houston Eye Associates for any unpaid medical / surgical procedures performed now or in the future. I also authorize Houston Eye Associate to release medical information to my insurance company (ies) or agent, now or in the future, for claim consideration purposes. I understand that payment for services does ultimately remain my responsibility.

NON-COVERED SERVICES: The filing of a claim for any service rendered DOES NOT GUARANTEE PAYMENT from your insurance company. You will be financially responsible for these services. Also, having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

DIVORCE DECREES: This office is NOT a party to your divorce decree, Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

MINOR PATIENTS: For unaccompanied minors,non-emergency treatment will be denied unless charges have been pre-authorized to an approved Credit Card, or payment by cash or check at the time of service has been verified.

EYE EXAM: I agree to and understand that my eye(s) must be dilated in order for the doctor to thoroughly check the retina of the eye. I agree to and understand that my eye may need to be patched as part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of Houston Eye Associates suggest that I evaluate my need for alternative transportation and the decision is soley mine, therefore I will not hold Houston Eye Associates responsible.

The contents of this document will remain in effect unless revoked by me in writing.

Name of Patient (Print)	Name of Witness (Print)
Signature of Patient	Signature of Witness
Date	Date
Signature of Patient Representative	
Relationship of Patient Representative to Patient	