WELCOME TO OUR OFFICE

Name____Date____/____/____

First **Middle Initial** **Last** **Suffix**

Address____City_________________ State________ Zip_________

Date of Birth: ______/______/______ Soc.Sec.#_____________________ Sex □ M □ F

Phone: Home #__________________ Cell#_________________Email______________________________________

Employer_______________________________ Occupation______________________Work#____________________

How did you hear about our office? □ Internet □ Yellowpages □ Friend/Family □ Other _______________________

Responsible Party (if different than above)

Person responsible for account__________________________________ Soc.Sec.#___________________________

Relation to patient______________________DOB___/___/_____ Preferred Phone___________________________

Address (if different from above)_____________________________City______________State________Zip _______

Medical/ Vision Insurance Information

Many eye problems are covered by your medical insurance

Major Medical Plan___________________________

ID #____

Group #_____________________________________

Subscriber's Name_____________________________

Subscriber's SS# ______________________________

Vision Plan______________________________________

ID #____

Group #____

Subscriber's Name________________________________

Subscriber's SS# __________________________________

All copays and individual portions of your balance are due at time of service. If you participate in any insurance plans, you are responsible for these amounts at the time of service. Eyes Fort Worth will bill your insurance directly for their portion. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize Eyes Fort Worth to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

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Patient Signature, Insured/Guardian **Date**

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf, to Eyes Fort Worth for any services furnished to me. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made authorizes releasing of the 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 authorized releasing of the information to the insurer 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,co-insurance,and non covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

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Beneficiary Signature, Insured/Guardian **Date**

Notice of Privacy Practices Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE SIGN AND DATE BELOW THAT YOU UNDERSTAND AND AGREE TO OUR NOTICE OF PRIVACY PRACTICES.

Sign that you understand and agree to our : **Signature:** ____

Date