EYECARE ASSOCIATES of EAST TEXAS

REGISTRATION FORM

PATIENT INFORMATION

Last Name ____________________ First Name ____________________ M.I. ______ Nickname ____________________

Marital Status: Single__________ Married__________ Divorced__________ Widowed__________ Legally Separated __________

Patient D.L.# ____________________ State ______ Social Security# ____________________ Date of Birth __________

Sex: Male / Female (circle one) Preferred Language: English______ Spanish______ Other____________________

Ethnicity: Hispanic/Latino_________ Not Hispanic/Latino_________

Race: Asian_____ White_____ American Indian or Alaska Native_____ Black or African American_____ Other_____

Emergency Contact: (relative, neighbor, or friend) ____________________ Phone# ____________________

Spouse Full Name:____________________ Phone# ____________________

Caretaker Full Name:____________________ Phone# ____________________

Patient Home Phone# ____________________ Work Phone#____________________ Cell Phone# ____________________

Preferred Contact By: Home#_____ Work#_____ Cell#_____ Is it okay to leave a detailed message? Yes_____ No_____

Email Address ____

Mailing Address ____________________ City ____________________ State ______ Zip __________

Employer Name ____________________ Not Employed__________ Retired __________

PERSON RESPONSIBLE FOR THE BILL *(ONLY APPLICABLE IF OTHER THAN THE PATIENT)*

Last Name ____________________ First Name ____________________ M.I. ______ Relationship to Patient ____________________

Social Security# ____________________ Date of Birth____________________

Mailing Address ____________________ City ____________________ State ______ Zip __________

Home Phone#____________________ Work Phone#____________________ Cell Phone# ____________________

INSURANCE INFORMATION *(PLEASE LIST POLICY HOLDER IF OTHER THAN THE PATIENT)*

Name ____ Date of Birth____________________

ADDITIONAL INFORMATION

Local Pharmacy ____________________ Address____________________

Mail-In Pharmacy ____________________ Address____________________

Referring Physician ____________________ City ____________________

Primary Care Physician____________________ City ____________________

How did you hear about EyeCare Associates?____

- OVER -

YOUR ELECTRONIC SIGNATURE IS REQUIRED TO CONFIRM YOUR UNDERSTANDING OF SPECIFIC EYECARE ASSOCIATES OF EAST TEXAS, PLLC POLICIES WHICH ARE OUTLINED BELOW.

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by EyeCare Associates of East Texas physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations and treatment. I acknowledge that no warranty of guarantee has been made to me as to result or cure.
I understand that this consent to treatment will be valid and remain in effect as long as I attend EyeCare Associates of East Texas clinics, unless revoked by me in writing.

RELEASE OF INFORMATION: I understand my signature authorizes release of confidential medical information necessary to pay the claim to Medicare or other health insurer.
I understand that I may revoke this authorization for the release of information at any time, by providing written notice to EyeCare Associates of East Texas, except to the extent that action has been taken in reliance on it.

RELEASE OF LIABILITY: I release and agree to hold harmless EyeCare Associates of East Texas and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand EyeCare Associates of East Texas cannot be responsible for use or re-disclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payor benefits for medical or health care services payable to me, payable to the providers of EyeCare Associates of East Texas. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payor, up to the total amount of my medical and health care charges to the providers of EyeCare Associates of East Texas. I certify that the information I have provided in connection with any application for payment by third party payors, including Medicare/Medicaid, is correct.
I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payor and agree to make payment as requested by EyeCare Associates of East Texas.

REFRACTION: I understand that refraction (measurement of eyes for glasses / contacts) is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

INSURANCE INFORMATION: At EyeCare Associates of East Texas we accept most major insurances, and assist our patients by filing claims to their primary and secondary insurances. All patients are required to pay any co-pays, deductibles, and non-covered items at time of service. Our goal is to refund an account credit balance as soon as possible.

INSURANCE COVERAGE - ROUTINE vs MEDICAL EYE EXAM: We strive to know what your insurance will cover, but also encourage our patients to become proactive in understanding their insurance coverage as well. One important concept to understand is that **Medical Insurance** covers medical problems, whereas, **Vision Plans** only cover routine eye care and hardware. Most frequently, you will have separate policies and cards for medical and vision coverage. Medical insurances usually do not cover routine vision services; however, some include limited routine vision benefits. Please familiarize yourself with your coverage prior to your visit. The reason for the visit, diagnosis of condition, and plan of treatment determine whether a visit is routine or medical from an insurance standpoint. Whether routine or medical, you can expect to receive a thorough exam and quality treatment at EyeCare Associates of East Texas. Here, we strive to help the patient in all areas of the *EyeCare* experience.

MEDICAL INSURANCE: In addition to commercial insurances, we work closely with the following government agencies: Texas Rehab, State Commission of the Blind, Texas Diabetic Council, Smith County Indigent, Medicaid, and Medicare (most Medicare Advantage/ Replacement Plans).

HMO MEMBERS: For most HMO insurance plans, you are responsible for obtaining a valid referral/authorization on your **initial** visit. After the initial visit, our staff can assist you with referrals/authorizations for future visits.

PRE-CERTIFICATION: Our staff will take care of all pre-certification requirements for certain surgeries or procedures.

VISION PLANS: For patients with routine vision coverage plans, please check before your visit to see if our doctors are on your plan.

EYECARE ASSOCIATES OF EAST TEXAS NOTICE OF PRIVATE PRACTICES: I acknowledge that a copy will be made available upon my request.

Witness Signature	Date	Patient / Agent / Guardian Signature	Date