Patient Information Form

NAME (last, first MI)____(Mr., Miss, Mrs., Dr.)
Address____
City, State, Zip____
SSN______-____-_________ DOB_______/________/________ SEX: M_____F______
Driver's License#_______________ Phone (Home)_____________ Work_______________
Employer/Occupation____
Who Referred You? ____
Primary Care Physician:____
ARE YOU UNDER THE CARE OF A SKILLED NURSING FACILITY? ________________________
IS THIS VISIT THE RESULT OF AN INJURY ON THE JOB? _______________________________

PRIMARY INSURANCE CARD HOLDER

Subscriber's Name______________________________ SSN______-____-_________
Relationship to Patient_________________________ DOB_______/________/_________
Insurance Company____
Secondary Insurance Company____

Co-payment and deductible payments as determined by your agreement with your insurance carrier are due at the time of service. We will file your insurance claim, but not all insurance plans cover all services. In the event your insurance plan determines a service "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. The following is a partial list of procedures commonly not covered by most medical insurance plans.

REFRACTION: Measurement of the lens power necessary to prescribe or change glasses and/or other corrective lenses. Refractions may also be done for diagnostic purposes. **The charge is $35.00 in addition to copayment for the visit.**

AFTER HOURS/EMERGENCY CARE VISIT: Any office visit occurring when the office is normally closed. The charge is $63.00 in addition to co-payment for the visit.

Financial Responsibility Agreement

I hereby authorize this office to apply for benefits on my behalf for services rendered. I thoroughly understand that my insurance is an agreement between the insurance provider and myself, not between the insurance provider and this office. If authorization is required from my primary care physician, I have obtained such documentation prior to the visit. I therefore request payment from my insurance company to be made to Eye Institute of Austin. I also understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any medical services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical records, to determine insurance benefits to which I may be entitled.

I acknowledge the receipt of notice of privacy practices of EYE INSTITUTE OF AUSTIN.

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Patient/Parent or Guardian Signature Date