Lone Star Vision
Eye Care & Optical

Section I- Patient Information:

Date: _____

Patient's Full Legal Name:_____ Nickname: _____

Patient's DOB: _____ SS #: _____ Sex: M F

Patient's Address:_____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone:_____ Daytime Phone: _____

Email:_____ How did you hear about us?_____

Approved Communication: (circle all that apply) Text Email Postal Phone

Marital Status: (please circle) Single Married Divorced Widowed

Preferred Language:_____ Race:_____ Ethnicity:_____

Employment/Student Status: (cirlcle one) Full-Time Part-Time Retired Unemployed College Student

Employer:_____Occupation:_____

Section II- Insurance Information:

Medical Insurance: _____ Phone #: _____

Member/Subscriber ID #: _____ Group/Acct #: _____

Vision Insurance: _____ Phone #: _____

Member ID #: _____ Group/Plan #: _____

Guarantor Information: (Policy Holder) Patient Relationship: (circle) Self Spouse Child Other:_____

Guarantor's Name: _____ Sex: Male Female

DOB: _____ SS#: _____ Employer:_____

Guarantor's Address:_____

City: _____ State: _____Zip:_____

Home Phone: _____ Cell: _____ Daytime: _____

Section III- Required Signatures

****Financial Policies/Responsibility****

***Many of the services provided in this office are covered and paid for by your insurance company. Unfortunately, not all services are paid by insurance. We do our best to have your benefits ready in advance and to charge you as accurately as possible. Insurance companies sometimes misquote benefits. Therefore, we cannot guarantee that your visit and services furnished will be paid in accordance to the quote we receive. Final determination of payment is not made until the claim is reviewed by the insurance company. In cases where the service has not been paid, you will be responsible for the charge. Before we bill you, we will make sure that all of the information provided to the insurance company is accurate and clearly describes the service you received.*

***Federal laws addressing all insurance companies require that we submit claims to the insurance company accurately, reporting the exact services performed and the exact reason for performing them. Our practice is committed to these laws and will submit claims to all insurance companies in this manner. We are not allowed to change this information so an insurance company will pay the claim. Any professional fees not covered by your insurance will need to be paid in full at the time of service.*

By signing below, you agree to pay for all services rendered to you, to the extent that you are legally responsible for. Understand that you are responsible for all insurance co-pays and deductibles or coinsurances. If however, we are not on your insurance plan, we will require full payment at the time of service for all medical services and products provided, but will provide you with an itemized receipt to submit to your insurance for potential reimbursement. Claims not paid due to errant or undisclosed insurance information provided by the patient will be the responsibility of the patient.

***I understand that payment collected today is based on a quote of benefits provided by my insurance carrier and therefore is not a guarantee of benefits. Final determination can only be made once the claim is reviewed by my insurance provider.*

I have read and understand the financial policy and I do accept financial responsibility:

_____ _____

(Signature of Responsible Party) (Date)

****Assignment of Insurance Benefits****

I authorize payment of my medical/vision benefits to Lone Star Vision. I authorize Lone Star Vision to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____

(Signature of Responsible Party) (Date)

****Disclosure of Protected Health Information****

I understand that any and all medical care that I receive at Lone Star Vision will be treated with the utmost confidentiality. To facilitate my medical care I hereby authorize Lone Star Vision to disclose information about my treatment and medical condition to the following individuals:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

My signature verifies that I have reviewed a copy of the HIPAA Privacy Statement.

_____ _____

(Signature of Responsible Party) (Date)

****Consent to treat a minor****

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

_____ _____

(Signature of Responsible Party) (Date)

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

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Section IV- Patient's Health Information

Patient's Name:_____ **Date:**_____

Referral Dr.: _____ **Reason:** _____

Medical History
(Please circle all that apply, If a family member please state relation)

Eye Disorders

Flashes/Floaters: ☐Self ☐ Family _____

Dry Eyes: ☐Self ☐Family _____

Blindness:☐Self ☐Family _____

Strabismus:☐Self ☐Family _____

Macular Degeneration:☐Self ☐Family_____

Cataracts:☐Self ☐Family _____

Retinal Detachments:☐Self ☐Family _____

Glaucoma: Self☐ ☐Family _____

Major Eye Injury/Surgery:
_____ Date: _____
_____ Date: _____

Other: _____
_____

Systemic Disorders

Diabetes:☐Self ☐Family _____

If Self, Date of diagnosis(MM/DD/YY):_____

High Blood Pressure:☐Self ☐Family _____

If Self, Date of diagnosis(MM/DD/YY):_____

Heart Disease: ☐Self ☐Family _____

If Self, Date of diagnosis(MM/DD/YY):_____

Arthritis:☐Self ☐Family _____

If Self, Date of diagnosis(MM/DD/YY):_____

Thyroid Disease: Self☐ ☐Family_____

If Self, Date of diagnosis(MM/DD/YY):_____

Other: _____
_____

Tobacco Product Use: ◉Yes ○No
Alcohol Use: ○None ◉Daily ○Socially
Drug Use: Yes○ No○

Drug Allergies: ○**No** ○**Yes, If yes please list:**

_____ _____

List Current Medications: (RX or Over the Counter, Include Eye Drops.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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