



TEXAS STATE OPTICAL

PATIENT GENERAL CONSENT/FINANCIAL RESPONSIBILITY FORM

Patient Name: _____ Date of Birth: _____

Appointment Time: _____ Arrival Time: _____

Patient's Height: _____ Patient's Weight: _____ (required because of Health Care Reform Act)

Primary Care Physician Name: _____ PCP Phone: _____

If you prefer us to send billing statements and/or other correspondence to an address other than your home address, please print that address below:

Street Address

City/State/Zip

Please list below any family member or other persons we may inform about your medical condition and your diagnosis. If for emergency only, please mark as such.

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Name: _____ Relationship _____ Phone: _____

Can we leave confidential messages such as appointment reminders on your home phone voicemail? Or, if you give us another number to call, can we do the same on that phone number? Yes _____ No _____

We are now making greater use of e-mail to communicate with our patients. To help us provide the most prompt service possible, please enter your current e-mail address below:

Grid for e-mail address input

NOTE: All patient information is kept strictly confidential. Your address is NEVER shared.

If we have something important to tell you or we can't contact you otherwise, would you like a text message sent to your cell phone? Yes _____ No _____ Cell Number: _____

Patient Signature (Parent/Guardian Signature if Patient is a Minor)

Date

Since we begin processing each order for glasses immediately, we are unable to make any cancellations after the close of business on the day the order is placed. Lenses are custom-made and are non-refundable. _____ (initials)

To Our Patients with Medical and Vision Benefits:

It is our pleasure to help you file your insurance claim forms or take assignment on your vision and/or medical benefits as designated by the plan(s) of which you indicated you are a member. We provide this service at no additional cost to you and will do all that we can to help you receive the maximum benefits allowable under your plan.

In the event the Plan Sponsor determines you are not eligible at the time of service or makes a determination that you are eligible for a reduced level of coverage, by signing this agreement, you do hereby agree to be financially responsible for any and all of the charges incurred by you and paid by the Plan Sponsor.

Patient Signature (Parent/Guardian Signature if Patient is a Minor)	Date
Vision Plan Name: _____	Member #: _____
Medical Plan Name: _____	Member #: _____
Individual Responsible for Payment of Unpaid Balances: _____	
Relationship to Patient: _____	Date: _____

***IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE BENEFITS (CO-PAYS, WHAT IS/IS NOT COVERED, ETC.), PLEASE ASK PRIOR TO SEEING THE DOCTOR AND WE WILL ASSIST YOU THE BEST WE CAN. ANY APPLICABLE CO-PAYS AND PAYMENT FOR ITEMS NOT COVERED BY YOUR INSURANCE WILL BE COLLECTED AT THE END OF YOUR VISIT AND PRIOR TO PLACING ANY ORDERS FOR MATERIALS.** _____ (initials)

Patient’s Billing Address:

Primary Insured’s Information:

Street Address

City, State, Zip

Phone Number/Cell Number

Employer

Social Security Number

Name

Date of Birth

Street Address

City, State, Zip

Phone Number

Social Security Number