



Chart # _____

Welcome to the TEXAS EYE INSTITUTE. Please complete all the information below.

HOW DID YOU LEARN ABOUT TEXAS EYE INSTITUTE?

Yellow Pages Ad (Paper, Billboard, Mail) Patient Physician Optometrist
Rockets Advertising Internet Other _____

If you were referred by a doctor, please fill in their name and address:

Referring Doctor's Name _____ Street _____ City _____ St _____ Zip _____

PATIENT INFORMATION

Name _____
First Middle Last

Address _____
Street City State Zip

Home _____ Work/Cell Phone _____ Social Security # _____

Email Address _____

Date of Birth _____ Age _____ Sex: M F Marital Status: S M W D

Occupation _____ Employer _____

Employer Address _____

In case of Emergency call: _____ Phone _____

PARENT/GUARDIAN INFORMATION (if patient is a minor)

Name _____
First Middle Last

Address _____
Street City State Zip

Home _____ Work Phone _____ Social Security # _____

Date of Birth _____ Age _____ Sex: M F Marital Status: S M W D

Occupation _____ Employer _____

RESPONSIBLE PERSON (if different from above for NON-MINOR)

Contact Person _____
First Middle Last

Address _____
Street City State Zip

Employer/Company/Agency Name _____ Phone _____

TEXAS EYE INSTITUTE

Responsibility of Account

Payment for all services is due at the time services are rendered unless prior arrangements have been made with this office. Please save all itemized statements for completion of your own insurance forms and for tax purposes. Patients of Texas Eye Institute are responsible for payment of fees to the doctor, and any reimbursement by the insurance company is strictly between the patient and their insurance company.

I acknowledge and understand that I am responsible for all charges for all services rendered to me. Although I may have requested that the doctor bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid. I further agree to make arrangements for obtaining a referral from my primary care physician and for prompt payment for any portion of my bill that is not paid by my insurance company. If for any reason insurance benefits exceed the outstanding account, I understand I will receive a reimbursement check from Texas Eye Institute.

ASSIGNMENT OF BENEFITS

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Texas Eye Institute. A copy of this can be considered an original for insurance purposes.

AUTHORIZATION FOR DISCLOSURE

I hereby authorize my employer or any person, company or entity to release or obtain any information which may be necessary to determine benefits payable under my insurance policy on which I am covered. A copy of this can be considered an original for insurance purposes.

MINOR PATIENTS

Unaccompanied minors will not be seen without the written or verbal approval of the minor's parent. In addition, for unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized to an approved credit card or payment by cash or check at the time of service has been verified.

EYE EXAM

I agree to and understand that my eye(s) must be dilated in order for the doctor to thoroughly check the retina of the eye. I agree to and understand that my eye may need to be patched as part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of Texas Eye Institute suggest that I evaluate my need for alternative transportation and the decision is solely mine, therefore, I will not hold Texas Eye Institute responsible.

The contents of this document will remain in effect unless revoked by me in writing.

Signature _____ Date _____
(Signature of patient or responsible party)

Patient's Name _____

*Texas Eye Institute
Notice of Privacy Practices*

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE ISSUED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY**

2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. You may also sign an authorization to disclose information to a friend or family member. Please indicate at the bottom of the page any person you authorize us to disclose information. You can later revoke it to stop any future disclosures but you must revoke this consent in writing. Any use or disclosure that has already occurred prior to this date, which you revocation of consent is received, will not be affected.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information. In addition, you may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. Texas Eye Institute may or may not agree to restrict the use and disclosure of protected information. If Texas Eye Institute agrees to our request, the restriction will be binding on the practice. Use and disclosure of protected information in violation of an agreed restriction will be a violation of the federal privacy standards.

4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice. The notice will be prominently displayed at all TEI locations and on our website. You can also request a copy of our notice at any time. For more information about our privacy policies, contact our Privacy Officer.

5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our Privacy Officer. You may send a written complaint to the U.S. Department of Health and Human Services. Our Privacy Officer can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact: Texas Eye Institute, Privacy Officer, 7710 Beechnut #100, Houston, TX 77074. Phone number: (713)777-7145.

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received the Notice of Privacy Practices.

Patient Signature: _____

Printed Name: _____ Date: _____

Patient Representative at Deemed by Patient: _____

Signature of Patient Representative : _____

Please give the Registrar your insurance card for copying, then complete the * lines on this form. If no card is available, then complete the entire form:

***Patient Name:** _____ **Chart #:** _____

Primary Insurance Company Name: _____

Address: _____

Phone#: _____ **Type of Insurance:** _____

Policy # _____ **Group Number:** _____

***Insured's (Policy Holder as it appears on card) Name:** _____

***Insured's Date of Birth:** ____/____/____ ***Insured's Gender:** Male / Female

***Patient's Relationship to Insured:** Self Child Spouse Other _____

Secondary Insurance Company Name: _____

Address: _____

Phone #: _____ **Type of Insurance:** _____

Policy #: _____ **Group Number:** _____

***Insured's (Policy Holder as it appears on card) Name:** _____

***Insured's Date of Birth:** ____/____/____ ***Insured's Gender:** Male / Female

***Patient's Relationship to Insured:** Self Child Spouse Other _____

Vision Insurance Company Name: _____

Address: _____

Phone #: _____ **Type of Insurance:** _____

Policy #: _____ **Group Number:** _____

***Insured's (Policy Holder as it appears on card) Name:** _____

***Insured's Date of Birth:** ____/____/____ ***Insured's Gender:** Male / Female

***Patient's Relationship to Insured:** Self Child Spouse Other _____