

TEXAS STATE OPTICAL - HUMBLE

Dr. Simon Yeung & Associates

Therapeutic Optometrists

WELCOME TO OUR OFFICE

We will be happy to help you fill out this form, ask for assistance.

Mr. Mrs. Miss. Ms. Dr. Date: Home Tel: CELL (ext )

Social Security # E-mail address:

Address: Apt # City: State: Zip:

Occupation (How you use your eyes) Sex: Date of Birth:

Reason for Visit: Last Exam: Last Doctor:

Referred by (circle): Family - Friend - Doctor - Yellow Page - Radio - Insurance - Coupon - Walk-In - Recall Card

Whom may we thank for the referral: Employer:

METHOD OF PAYMENT: Please circle - Cash - Check - AmEx - Visa - Master - Discover - Medicaid (Card #

EXAMINATION FEES ARE NOT REFUNDABLE

INSURANCE INFORMATION

Primary Insurance Carrier: Policy Number:

IF NAME ON INSURANCE CARD IS OTHER THAN PATIENT

Insured's Name: Relationship to Patient:

Insured's Soc. Security #: Date of Birth:

Secondary Insurance Carrier: Policy Number:

Insured's Name: Relationship to Patient:

If no insurance, are you responsible for your fees? Yes No If not, who is?

Name: Relationship:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I am acknowledging that I have been provided with a copy of Texas State Optical Privacy notice pursuant to the Federal regulations known as the HIPAA Privacy Rule.

Name: Relationship to Patient:

Signature: Date:

FINANCIAL ASSIGNMENT AND AGREEMENT

I authorize all insurance benefits to be paid directly to Texas State Optical and agree to be financially responsible for any remaining balance (deductibles, co-insurance, refractions, eyeglasses or any other balance not paid by the insurance). I also authorize Texas State Optical to release information regarding myself and my medical treatment to insurance companies, hospitals, surgery centers, and physicians as deemed professionally necessary for treatment and to process my insurance claims.

Signature: Date: