TSO™
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:

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:

_____
Street Address

_____
City, State, Zip

_____
Phone Number/Cell Number

_____
Employer

_____
Social Security Number

Primary Insured's Information:

_____
Name

_____
Date of Birth

_____
Street Address

_____
City, State, Zip

_____
Phone Number

_____
Social Security Number