



Lone Star Vision

Eye Care & Optical

Section I- Patient Information:

Date: _____ Referral Source: _____ Email: _____

Patient's Full Legal Name: _____

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

Preferred Language: _____ Race: _____ Ethnicity: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

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

Communication Preference: Email, Postal, Telephone Marital Status: _____

Employment/Student Status: _____ Occupation: _____

Employer: _____

Section II- Guarantor Information: (Responsible Person/Subscriber)

Guarantor's Name: _____ Relationship to Patient: _____

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

Guarantor's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Daytime: _____

Section III- Insurance Information:

Primary Medical Insurance Company: _____

Provider Inquiry Phone #: _____

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

Please continue onto the back of this page

Section IV- Vision Insurance Information:

Vision Insurance Carrier: _____

Provider Inquiry Phone #: _____

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

****Financial Policies**Your Financial 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 personally 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 an insurance company accurately, reporting the exact services performed and the exact reason for performing them. We are not allowed to change this information just so an insurance company will pay the claim. Our practice is committed to these laws and will submit claims to all insurance companies in this manner. 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 co insurances. 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)

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

(Signature of Responsible Party) (Date)



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Section V- Patient's Health Information

Patient's Name: _____ Date: _____

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

Medical History:
(Circle S for Self or F for Family)

Eye Disorders

Flashes/Floaters: S F

Dry Eyes: S F

Blindness: S F

Strabismus : S F

Macular Degeneration: S F

Cataracts: S F

Do you use tobacco products: Yes No

Retinal Detachments: S F

Do you drink alcohol: Yes No Occasionally

Glaucoma: S F

Drug Use: Yes No

Other: _____

Allergies to food or drugs: Yes No
(Please list)

Systemic Disorders

Diabetes: S F

High Blood Pressure: S F

Heart Disease: S F

Arthritis: S F

Thyroid Disease: S F

Other: _____

For Office Use Only:

Date Reviewed: _____ Tech Initials: _____

Date Reviewed: _____ Tech Initials: _____

Date Reviewed: _____ Tech Initials: _____