



SACHSE FAMILY EYE CLINIC

*Advanced Eye Care & Optical Services
5001 Ben Davis Rd Sachse, Tx 75048*

*Thank you for choosing the Sachse Family Eye Clinic,
your eyes are our number one priority!*

If you have seen us before, please update us. If no change, write "no change"

PATIENT REGISTRATION FORM

Last Name _____ Frist Name _____ DOB _____ Soc Sec# _____

How did you hear about us? _____

GENDER M F MARITAL STATUS: CHILD SINGLE MARRIED DIVORCED OTHER

ADDRESS _____

CITY _____ STATE _____ ZIP _____

WORK PH _____ CELL _____

EMPLOYED SELF EMPLOYED UNEMPLOYED FULL TIME STUDENT DISABLED RETIRED
 OTHER _____

HIPPA PRIVACY POLICY

_____ I have received a welcome packet that includes exam protocols, billing, insurance and collections policies, and our HIPPA Privacy policy.
I would like to release and allow access to my medical records to the following people:

Name	Address	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check the preferred choice of payment:

Cash Check Visa MasterCard American Express Discover

Billing & collection processes have become increasingly expensive. Please help us keep the cost of your medical care as low as possible by being prepared to pay for your services at the time of your office visit. Our first concern is for your eye care; if you are having difficulty, it is important to let us know so that we can work out mutually suitable arrangements.

PLEASE PROVIDE ALL INSURANCE INFORMATION BEFORE YOUR EXAM.

If you do not provide your insurance information and find out that you have insurance benefits we will issue invoices and necessary documents so that you can submit for reimbursement. We will not be able to back date, refund or submit a claim on your behalf if insurance information is not provided at the time of service.

Also, we go through great lengths to verify the amount and type of coverage you are allowed under you plan. However, when given the information at the time of service, eligibility does not guarantee payment by your insurance plan or sponsor. In the event the plan or insurance carrier determines that you are not eligible or makes determination that you are eligible for a reduced level of coverage or applies the charges to your deductible, by signing this statement you agree to be financially responsible for any and all of the charges incurred by you and not paid by the insurance carrier.

I assign payment from my insurance company to the Sachse Family Eye Clinic, PLLC. I understand that I am financially responsible for services I have consented to at the Sachse Family Eye Clinic, including deductibles and other charges not covered by insurance. I authorize medical information to be released to my insurance carrier about my visit.

Legal Signature or Parent/Guardian Signature

Date