WHITSETT
VISION GROUP

PATIENT INFORMATION

Last Name: First Name: MI		Other Names Used:			
Preferred Language	**Marital Status:**	**Birth date:**	**Age:**	**Sex:**	
❑ English ❑ Spanish ❑ Other: Please list _____	❑Single ❑Married ❑Divorced ❑Separated ❑Widow	/ /		❑ Male	❑ Female
Street Address/ Apt/Suite :		**City:**		**State:**	**Zip code:**
Email Address:					
Cell Phone No:		**Alternate Phone No.:**			
Emergency Contact:		**Phone Number:**			
Race (Select one or more) ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other :_____ ❑ Unknown / Declined to Report **Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino					
MD/Optometrist Name:		**Referring Physician Name:**			
How did you hear about us? (please check one box):	❑ Friend	❑ Katy Magazine	❑ Insurance Plan	❑ Health Fair	
	❑ ZOC DOC	Other:			

PERMISSION TO RELEASE INFORMATION

Please list the names of people that we may contact and share information with regarding your health and private information. This does not need to include other healthcare providers or insurance companies, as they are included in your circle of care. **An example would be your spouse, children, relative or close friend.**

Name:	**Phone No:**
Name:	**Phone No:**
Name:	**Phone No:**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received a Notice of Privacy Practices from the Office of Whitsett Vision Group.

Parent/Guardian Signature:	**Date:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand any referral that is required by my insurance I will fully be responsibly to obtain, not the office. I also authorize WHITSETT VISION GROUP or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	**Date**

WHITSETT VISION GROUP

MEDICAL HISTORY INFORMATION

Patient Name:	Date of Birth:	Date:
Retail Pharmacy:	Address:	Phone No.:
Mail Order Pharmacy:	Address:	Phone No:
Family Physician:	Height:	Weight:

Medical History (including chronic illnesses, eye disease, eye trauma):

Medication Allergies:

Current Medications (including eye drops):

Medication Name:	Dosage:	Purpose:

Surgical History (including eye surgeries):

Surgery Name:	Year:

Family History (please indicate which family member):

	Mother	Father	Brother	Sister	Daughter	Son
Diabetes						
High Blood Pressure						
Heart Disease						
Lung Disease						
Glaucoma						
Retinal Disease						
Macular Degeneration						
Cataracts						

Social History:

Do you drink alcohol? ☐ YES ☐ NO	If yes, which type?
Do you smoke? ☐ YES ☐ NO	If yes, which type?
Have you ever quit?	If yes, when?

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PATIENT FINANCIAL RESPONSIBILITY AND REFERRAL WAIVER

Whitsett Vision Group (WVG) is committed to serving its patients with courteous, efficient, high-quality service. Pleasing our patients is our number one priority. As a courtesy to our patients, WVG files the patient's insurance and makes every effort to ensure that claims are promptly and correctly processed.
The purpose of this form is to assist our patients in understanding their medical insurance coverage in relationship to our office policies.

- Patients are responsible for knowing and understanding their own insurance policy, eligibility, and coverage.
- If you are currently without insurance coverage, WVG requires payment in full at the time services are provided. A 20% self-pay discount is offered as an adjustment to our usual and customary charges.
- We render our services on the basis that insurance companies may or may not pay for all but a portion of our charges.
- Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for services rendered.
- Not all insurance companies/third party payors pay for all services, each policy has its own particular stipulations regarding covered services or amount of coverage.
- All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.
- Patients are responsible for payment of outstanding deductibles and co-insurance amounts at time of service. Co-payments will be collected at the time of service.
- If your insurance company requires a referral, it is your responsibility to obtain it prior to the visit and have it at the time of the visit. ***FAILURE TO OBTAIN THE REFERRAL AND/OR PREAUTHORIZATION WILL RESULT IN A LOWER OR NON-PAYMENT FROM YOUR INSURANCE COMPANY, AND THE BALANCE WILL BE YOUR RESPONSIBILITY AT THE TIME SERVICES ARE RENDERED.***
- Patients are financially responsible for payments of all non-authorized procedures, office visits lacking a proper insurance referral, and non-covered services.
- Returned checks are subject to a $35.00 service charge to your account along with the insufficient funds amount.
- Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.

I understand, acknowledge and agree that I am financially responsible for my deductible, co-insurance, and any amount exceeding what my insurance company pays except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, pre-authorizations, and second opinions.

I HAVE READ THE ABOVE WAIVER, AUTHORIZATION AND ACKNOWLEDGEMENT AND/OR IT HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS AND THAT I AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Patient's Printed Name:	**Patient Date of Birth:**
Patient/Guardian Signature:	**Date:**
Witness Signature:	**Date:**