



5900 Coit Road, Suite 2  
Plano, TX 75023  
972-596-2224

## PATIENT INFORMATION

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### PATIENT

NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_ AGE \_\_\_\_\_  
BIRTH DATE \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SOCIAL SECURITY # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ MARITAL STATUS \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
EMPLOYER'S ADDRESS \_\_\_\_\_

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### IN CASE OF EMERGENCY

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

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### INSURANCE

VISION INSURANCE COMPANY \_\_\_\_\_  
NAME OF INSURED: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_  
BIRTH DATE \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SOCIAL SECURITY # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ RELATION TO PATIENT \_\_\_\_\_  
PRIMARY MEDICAL INSURANCE COMPANY \_\_\_\_\_  
NAME OF INSURED: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_  
BIRTH DATE \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SOCIAL SECURITY # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ RELATION TO PATIENT \_\_\_\_\_  
SECONDARY MEDICAL INSURANCE COMPANY \_\_\_\_\_  
NAME OF INSURED: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_  
BIRTH DATE \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SOCIAL SECURITY # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ RELATION TO PATIENT \_\_\_\_\_



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## CONDITIONS OF SERVICE

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### CONSENT TO TREATMENT

Rosemore Eye Care is licensed to provide both Routine Eye Exams and Medical Eye Exams. Please be advised that if you are being seen today for a Routine Eye Exam that based upon any or a combination of the following concerns: family history, current medical disease and/or conditions, chief complaint, pre-test findings, or a condition found during the course of the exam, the Doctor may find it necessary to move from a Routine Exam to a Medical Exam as well as order additional tests. The Doctor will notify you during the course of the exam when they determine a Medical Exam is required. When a Medical Exam is required, be advised it is not a covered item under your Routine Eye Exam benefits through your Vision Insurance Plan. Medical Exams are billed through your Major Medical Carrier and are subject to their specific Copays, Deductibles, and Co-Insurance, which will be due at the time of service. In the event I do not wish the Doctor to proceed with a Medical Examination, I understand it is my responsibility to immediately inform the Doctor so that he/she can refer me out to the appropriate Doctor or Specialist.

### RELEASE OF INFORMATION

Subject to State and Federal regulations, Rosemore Eye Care may disclose all or any part of the patient's record for this service to any person or corporation which is or may be liable under a contract to the Optometrist, or to a family member or employer of the patient for all or part of the provider's charges, including, but not limited to hospital or medical service companies, insurance companies, worker's compensation carrier, welfare funds and all authorized auditors as specified in the Insurance Carrier Guidelines and referring professionals. Additionally, I hereby authorize Rosemore Eye Care to release to my insurance company any information concerning and procedures performed during this treatment and the final diagnosis, as well as, information contained on this form.

### MEDICARE/MEDICAID PATIENT'S CERTIFICATION

I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me release to the Social Security Administration or its intermediaries or carriers any information needed to process any claim on this or any related service. I request that payment of authorized benefits be made in my behalf directly to Rosemore Eye Care for its charges and for any charges of Physicians for whom the facility is authorized to bill in connection with its services.

### ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby declare that I have been given an opportunity to read and/or have read and understand the facility's Policy of Privacy Practices.

### FINANCIAL ACKNOWLEDGEMENTS

I hereby authorize any person/institution rendering care to furnish all facts concerning this claim. I authorize payment for my vision benefits to go directly to Rosemore Eye Care. I authorize Rosemore Eye Care to deposit checks received on my account made out to me for services rendered. **I agree that if my employer, insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges.** I agree to pay a service fee of **\$20.00** for each check or other instrument tendered by me, but returned to Rosemore Eye Care. In the event it should become necessary to place any unpaid balance due for services rendered to me or my family for collection, I/we agree to pay interest at the rate of 1.5% per month/18% per year, collection fees, and should legal action be filed, reasonable attorney fees, filing fees, and other costs the court determines proper. I have read the "Conditions of Service" on the reverse side, and as the Patient, or the Patient's authorized representative or General Agent for the purpose of signing this document, hereby accept it's terms. **Authorization obtained at time of service does not guarantee payment and any denied services will be balance billed to the patient.**

SIGNATURE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_