Burnet Eye Care & Llano Eye Care
P.O. Box 426 • Burnet, TX 78611• 512-756-2131 phone
102 E Young St • Llano, TX 78643 • 325-247-2020 phone

PATIENT REGISTRATION – PLEASE PRINT

Patient's Name____ Today's Date ___________________

Mailing Address_____________________________City_________________State________Zip_____________

Social Security # __________ - _______ - _________ Date of Birth ___________________ Gender ☐F ☐M

Cell (_____) ______-____________ Home (_____) ______-____________ Work (_____) _____-_____________

Email____

Employer________________________________ Occupation________________________

Is it OK for us to leave a message at your place of employment? ☐Y ☐N

Preferred Method of contact:
☐Home phone
☐Cell phone
☐Work phone
☐Mail

Race:
☐American Indian/Alaskan Native
☐Asian
☐Black/African American
☐White
☐Native Hawaiian/Pacific Islander

Ethnicity:
☐Not Hispanic/Latino
☐Hispanic/Latino
☐Decline to answer

Primary Language:
☐English
☐Spanish
☐Other________________________

ACCOUNT RESPONSIBLE: IF PATIENT IS A *MINOR or if someone OTHER than the patient is financially responsible:*

Parent's/Guardian's/Facility Name____

Address____Phone(_____) _____-________________

Do you have MEDICARE? ☐Y ☐N

MEDICAID? ☐Y ☐N

HEALTH INS? ☐Y ☐N Name of Insurance_____________________________________

VISION PLAN? ☐Y ☐N Name of Vision Plan____________________________________

Are you currently living in a SNF (skilled nursing facility) for rehabilitation only? ☐Y ☐N

Name of facility________________________________Phone(_____) _____-_____________

Mailing address________________________________City_________________State____Zip___________

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

***If you are 18 or older and you want another person or family member to have access to your medical records, account information, or prescription, please indicate by providing details below.**
I authorize Burnet Eye Care / Llano Eye Care to release health information identifying me under the following conditions: Any and all eye health, personal health, account, or insurance information in my records to:

___________________________________Relationship________________Phone______________________

___________________________________Relationship________________Phone______________________

You may revoke this authorization at any time by contacting our Privacy Officer in writing as noted in the *Privacy Practices Policy.*

PAYMENT, INSURANCE / VISION PLANS, and FINANCIAL INFORMATION

Payment is due at the time services are rendered. Cash, Check, Visa, MasterCard, Discover, and American Express are accepted as payment. Please present **ALL** insurance cards at the front desk when you arrive. We are **UNABLE** to make a claim on your insurance or vision plan **AFTER** the date of service. Burnet/Llano Eye Care contract with many insurers and vision plans to accept assignment of benefits. We will bill those plans for which we have an agreement and will require you to pay the authorized co-payment/co-insurance at the time of service. If it is determined that you do not have benefits to cover today's visit, you have been seen out of network, or your insurance determines a service "not covered," ***please understand that you are responsible for payment for today's services.***

I certify that the insurance information given by me is true and correct. I authorize the doctor to act as my agent in helping me obtain payment of my insurance benefits, and I request that payment of these benefits be made on my behalf to Burnet/Llano Eye Care for any services and materials furnished. I authorize Burnet/Llano Eye Care to release any information necessary to insurance carriers regarding my diagnosis and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing. Accounts that become delinquent may be referred to a collections agency and you are responsible for collection costs in addition to your outstanding balance. There is a $30.00 fee for checks returned by the bank.

CANCELLATION POLICY

If unable to keep your appointment, we require 24 hours notice; otherwise we reserve the right to charge $35.00 late cancellation/no show fee for time reserved.

CONSENT TO TREAT

I have requested medical services from Burnet/Llano Eye Care on behalf of myself and/or my dependents. I agree to and understand that my Doctor may request that my eye(s) be dilated in order to thoroughly check the retina. I agree to and understand that my eye(s) may need to be patched as part of treatment. I understand that if my pupils are dilated or my eye is patched after the eye exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of Burnet/Llano Eye Care request and urge that I arrange alternate transportation.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES AND POLICIES DEFINED ABOVE

I have been made aware of and/or reviewed this office's Notice of Privacy Practices, which explains how my medical information may be used or disclosed. I understand that I am entitled to receive a copy of this document upon request.

EXAMS FOR CONTACT LENSES REQUIRE ADDITIONAL FEES FOR SERVICE

Do you normally wear contact lenses? ☐Y ☐N
Do you want to continue as a contact lens patient? ☐Y ☐N
I am interested in wearing contacts. ☐Y ☐N

_____Contact lens wearers, please initial here to indicate that you have read and agree to our Contact Lens Agreement.

SIGNATURE OF RESPONSIBLE PARTY: _________________________________Date: _________________