TSO™
TEXAS STATE OPTICAL
www.tsowoodlands.com

PATIENT REGISTRATION AND CONSENT FORM

Welcome to our office! If you should need assistance in completing this form, please ask a staff member for help.

PATIENT INFORMATION

Last Name: _____ First Name: _____Middle Initial: _____

Preferred Name (if applicable):_____ Status: ☐Child ☐Single☐Married☐Widowed☐Separated ☐Divorced

Street Address: _____ Apt# _____ City:_____ State: ____ Zip:_____

Date of Birth: _____ Sex: ☐Male ☐Female Social Security # _____

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

CellPhone:(_____)_____ Home Phone: (_____)_____ Work Phone:(_____)_____

Email Address: _____

Occupation: _____ Employer (or School if student):_____

How were you referred to us? ☐Family/Friend ☐Physician ☐Internet ☐Insurance ☐Newspaper ☐Phone Book ☐Radio ☐Walk-In ☐Other

If personally referred, whom may we thank for the referral?_____

GUARANTOR INFORMATION (If patient is a Minor or Dependent)

Last Name: _____First Name: _____Middle Initial: _____

Street Address: _____ Apt# _____City:_____ State: ____Zip:_____

Date of Birth: _____ Sex: ☐Male ☐Female Social Security # _____

CellPhone:(_____)_____ Home Phone: (_____)_____ Work Phone:(_____)_____

Relationship to Patient: _____ Email Address: _____

COMMUNICATION PREFERENCE

In order for our office to better communicate with you, please indicate your preferences below:

What is your primary phone contact?☐Cell Phone ☐Home Phone ☐Work Phone

May we send you text messages (i.e. glasses ready for pick-up, appt. reminders)? ☐Yes ☐No If yes, please list your cellular provider _____

May we communicate with you by email? ☐Yes ☐ No

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. We are required by law to maintain the privacy of your health information and make every effort to inform you of your rights. The Notice contains a section describing your rights under the law related to your personal health information. You have a right to review our Notice of Privacy Practices before signing this consent.

By signing below, I acknowledge that I have reviewed or had explained to me TSO Woodlands' Notice of Privacy Practices and agree to continue my care with TSO Woodlands under said terms.

_____ _____

Patient or Guarantor Signature **Date**

INSURANCE AUTHORIZATION AND FINANCIAL RESPONSIBILITY DISCLOSURE

My signature below authorizesLinh T. Yee-Young, O.D., P.A. dba TSO Woodlands to release any medical information necessary to process my or my dependent's insurance claim. I authorize any benefits due be paid directly to TSO Woodlands.

Your insurance company only provides our office an "estimate" of covered benefits prior to receiving any services or materials from us. This "estimate" is not a guarantee of benefits. I understand that I may be required to pay a deductible, co-pay, co-insurance, or any balance not covered by my insurance plan. In the event that my insurance does not fully pay for services and/or materials rendered to me, I agree to be responsible for payment of all balances on my or my dependent's behalf.

I understand that all **fees for professional services shall be paid at time of service and are NON-REFUNDABLE.** Anyreturned check will incur a $30 fee. Iam also aware that prescription eyeglasses are a custom order therefore, any cancellation after 24 hours of placing the order will be NON-REFUNDABLE.

I certify that I have read and understand the above information to the best of my knowledge.

_____ _____

Patient or Guarantor Signature **Date**