EYES & OPTICS
Pearland

Detailed no show policy: effective 1/02/2018

Our office utilizes an automatic recall system to remind you of your appointments by text and email several times prior to your scheduled appointment with us.

1. Cancellation no show policy for the doctor appointment:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work and family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting on our schedule. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is **not canceled 24 hours in advance, you will be charged the $25 fee**; it will be the patient's responsibility to pay as this will not be covered by your insurance. Failure to pay within 30 days of the scheduled appointment will result in collection fees in addition to the balance owed.

2. Scheduled appointments that are running late

We understand that delays can happen however we must try to keep the other patients and the doctor on time. If you are **10 minutes past** your scheduled time we may have to reschedule the appointment if the schedule does not allow for the delay.

3. Account balances

We do require that the balances are paid in full at the time of services, and any previous account balances (self or family) are paid in full prior to receiving further services by our practice. failure to pay balance has 30 days within the appointment date can result and being sent to collections. It is not a pleasant experience for our office or for you to deal with collections and we would appreciate your timely attention to balances that are owed.

Patient Printed Name: _____

Patient/Parent/Guardian Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to our patients. We are required to provide you a copy of our notice of privacy practices, which states how we may use and or disclosure health information please sign this form to acknowledge receipt of this notice.

You May Refuse to Sign This Acknowledgement

I acknowledge that I have received a copy of this offices notice of privacy practices.

Please Print (patient's) Name: _____

Print your name: _____

Patient/Parent/legal Guardian Signature: _____

Date: _____

OFFICE USE:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communications baniers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____Other (Please Specify)

_____ _____

Employee signature Date

HipAA acknowledgement of receipt of the notice of privacy practices
This one does not constitute legal advice and covers only Federal, not state law

Insurance information

Insurance is billed as a courtesy to you. By signing this form below, it gives our office your authorization to release your personal information to the insurance company. This office does not submit secondary entrance or out-of-network plans and is the patient responsibility. The patient or legal guardian is responsible for all remaining balances not paid by your insurance company. As stated by your insurance provider, authorization of your benefits does not provide a guarantee of payment and that final determination can only be made when the claim is processed. Payment of outstanding balances are due within 30 days. Medical visits are filed under medical insurance plans and specialist copays are due at every visit.

By signing below, I acknowledge and agree to the terms of this form in its entirety.

Printed Name: _____

Responsible Party Signature: _____

Date: _____

RESPONSIBLE PARTY INFORMATION

Please list the person who is financially responsible for the account. Please verify that we have your accurate information.

Mr. Mrs. Miss Ms. Parent of (child name) : _____

First Name: _____ Last Name: _____

Address: _____

City: Houston Pearland Manvel Fresno State: TX _____ Zip Code: _____

Cell Phone: _____ Alternative Phone: _____

Date of Birth: _____ Last four of Social Security _____

Email Address: _____@ _____

Vision Insurance : VSP Eyemed Superior Vision

Medical Insurance Name: _____

ID # _____ Group # _____

Policy Holder Name _____ Policy Date of Birth: _____

Policy Holders Last four of Social Security Number: _____

We require that patient fees are paid at the time services are rendered. Orders will not be processed until balances are paid in full. The undersigned will be responsible for any bills incurred in this office regardless of insurance. **Accounts 30 days past due are subject to collection and legal fees in addition to the balance owed. There will be a service charge on all returned checks.**

Please ensure that you are completely happy with your selections as **all sales are final.** Contact lens fees are separate from the comprehensive exam and fitting fees will apply. Our office allows 30 days to finish contact lens fits after which refitting fees apply. It is a patient's responsibility to return for their appointments as indicated. For contact lens follow-ups, contacts should be worn at least 2 hours prior to your scheduled appointment.