RESET FORM

*THE OFFICE OF*
**ROBERT S. THOMPSON, O.D.**
**EYES OF SAN ANTONIO**
**CONFIDENTIAL PATIENT INFORMATION**

_____/_____/_____

***PLEASE PRINT***

☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss _____ ☐Male ☐Female
Address: _____ City/State:_____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone:_____
Email: _____ Marital Status: _____
Age: _____ Date of Birth: _____/_____/_____ SS #:_____ Driver's License #: _____
Employer: _____ Occupation: _____

Parent/Guardian Name or Spouse's Name: _____
Cell Phone: _____ Work Phone: _____ Employer: _____
Other family members living at home:
Name:_____ Age:_____ Name:_____ Age:_____
Name:_____ Age:_____ Name:_____ Age:_____

In Case of Emergency, Contact: _____ Phone: _____
Primary Care Physician: _____ Date of Last Visit: _____
Referred by: ☐Phone Book ☐Insurance ☐School ☐Drive By ☐Advertisement ☐Patient _____
Doctor _____ Other _____

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***As a courtesy, we will file most primary insurance claims for you if we have the following information:***

1. ***Photocopies of the front and back of your valid, insurance ID card(s).***
2. ***Authorization to file insurance claims and receive direct payment for services.***
3. ***Notification of changes in your insurance coverage, address or phone number.***

**Primary Medical Insurance: _____ Phone #: _____**
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder Date of Birth: _____ Employer: _____ PCP Referral Required? ☐Yes ☐No
Policy #: _____ Group #: _____ PCP:_____

**Secondary Medical Insurance: _____ Phone #: _____**
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder Date of Birth: _____ Employer: _____ PCP Referral Required? ☐Yes ☐No
Policy #: _____ Group #: _____ PCP:_____

**Vision Plan: _____ Phone #: _____**
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder Date of Birth: _____ Employer: _____
Policy #: _____ Group #: _____

**ROBERT S. THOMPSON, O.D.**
**EYES OF SAN ANTONIO**
**INFORMED CONSENT & TREATMENT AUTHORIZATION**

- I (do) ____ (do not) ____ authorize Robert S. Thompson, O.D., and/or his staff to leave a message with available persons at my home phone number, on my answering machine or with the emergency contact listed above.
- I (do) ____ (do not) ____ authorize Robert S. Thompson, O.D., and/or his staff to leave a message at my place of employment.
- I (have) ____ (have not) ____ been provided a copy of the Privacy Practices of Robert S. Thompson, O.D.

I hereby authorize Robert S. Thompson, O.D., to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care.

_____ _____

Patient or Legal Guardian's Signature Date

**FINANCIAL & INSURANCE FILING POLICY**

- *All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or copay*
- *If your insurance company does not pay your claim within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, you are responsible for payment.*
- *Payment for copay and/or deductible is due at the time services are rendered.*
- *We accept cash, checks, money orders, Visa and Mastercard.*
- *Refraction is not covered by your insurance; therefore you will be charged a fee in addition to your copay and/or deductible.*

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS**

***I _____, authorize the release of all necessary Protected Health Information and assign all medical and vision benefits to Robert S. Thompson, O.D. I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to Robert S. Thompson, O.D. for any services furnished to me by Robert S. Thompson, O.D. I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, copay, and non-covered services. Copay and deductible are based upon the charge determination of the Medicare carrier. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any and all legal fees, court costs, and collection charges. There will be a service charge for each returned check. This authorization and assignment will remain in effect until revoked by me in writing. A photocopy of this authorization and assignment is to be considered as valid as the original. I request that you file my insurance and I have agreed to and completed all of the conditions listed above. I accept financial responsibility for all charges. I have read and understood this information and I am signing voluntarily.***

_____ _____

Patient or Legal Guardian's Signature Date