

**PERSONAL DATA**

Today's Date: \_\_\_\_\_ Title: Mr. Mrs. Ms. Dr. Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Male Female  
Last Name First Name Middle Name

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_  Check here to receive our complimentary newsletter containing important eye care information via email

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

SS#: \_\_\_\_\_ Driver's License # \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Referred by: \_\_\_\_\_ Who may we thank for referring you here? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name Relationship Phone Number

**FINANCIAL RESPONSIBLE PARTY**

Same as above

Name: \_\_\_\_\_ Male Female  
Last Name First Name Middle Name

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SS#: \_\_\_\_\_ Driver's License # \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**INSURANCE**

Name of **Primary Medical/Health** Insurance Company: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name First Name Middle Initial

Policy No: \_\_\_\_\_ Group No.: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of **Secondary Medical/Health** Insurance Company: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name First Name Middle Initial

Policy No: \_\_\_\_\_ Group No.: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of **Vision** Insurance Company: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name First Name Middle Initial

Policy No: \_\_\_\_\_ Group No.: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**COMMUNICATING TEST RESULTS & REPORTS**

We may need to communicate test results and/or reports to you. Please indicate what phone number you would prefer us to call with any such information: \_\_\_\_\_

- Do not discuss my medical care or my account with anyone but me.
- You have my permission to leave a message at the above number regarding my medical care or my account.
- You have my permission to discuss my medical care or my account with \_\_\_\_\_.

**OFFICE POLICY & INFORMATION**

**Financial Policy:**

Insurance coverage is an arrangement between the insurance carrier and the patient. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. Ultimately, you and only you are responsible for understanding the specifics of your insurance plan. You bear full financial responsibility for the services rendered and products provided by Sugarland Eye & Laser Center and agree to pay at the time of service. Additionally, you authorize and request that insurance payments be made directly to Amjad Khokhar, M.D. and/or Sugarland Eye & Laser Center, P.A. should they elect to receive such payments.

Payments that you are responsible for include but are not limited to any and all copayments, coinsurances, and deductibles. You have agreed with your insurance company to pay these at each doctor's office visit. Please note that copayments for office visits are usually higher for specialists (like ophthalmologists) versus primary-care physicians. So check with your insurance carrier to determine if you have a higher copayment for specialists. Additional diagnostic and therapeutic procedures may be subject to separate copayments, coinsurances, and deductibles than your office visit. Again, check with your insurance carrier to determine how your benefits apply.

Though Sugarland Eye & Laser Center will attempt to determine and collect your payment responsibility at the time of service, you understand that you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company within 30 days of being notified by either your insurance company or Sugarland Eye & Laser Center. Our charges may be estimated based on each insurance company's fee schedule. After your insurance processes the claim and if a balance is due you will receive a statement. If a refund is due, we will be happy to mail it to you.

**Authorization for Treatment / Referrals (HMO & POS Plans):**

You are responsible for obtaining an authorization for examinations & treatments if required by your insurance company. Often separate referrals will be required for examinations, diagnostic tests, and procedures. Though we may attempt to assist you in obtaining a referral as a courtesy, it is your responsibility to have authorization on file with us before your visit. Otherwise, the insurance company will not pay for your visit. Without a referral you have the option to receive services on a fee for service basis.

**Keeping Your Account Up-To-Date:**

It is your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Please have your insurance card available at all office visits. Insurance companies gives us 90 days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide the correct information, the visit will be your responsibility.

**Delinquent Accounts:**

Accounts turned over to a collections agency will be assessed a \$25.00 fee. You may also be given notice legally dismissing you from our practice and be asked to find another physician. You agree to pay all reasonable attorney fees and collection costs in the event of default of payment. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed.

**Return Checks:** There will be a \$25.00 charge for all returned or cancelled checks.

**Release of Medical Records:**

There will be a \$25 charge for copies up to 20 pages. Each additional page is \$0.50. If you need any insurance forms completed by our office, there will be a \$50.00 charge. You authorize us to release of all medical records to the referring and family physicians and to your insurance company, if applicable. You allow fax transmittal of your medical records, if necessary.

**Business Hours:**

Monday – Friday 8:00 AM – 5:00 PM

**Late or Missed Appointments:**

If you are unable to keep your appointment, please call to reschedule at least 24 hours prior to your visit to allow someone else to take your place. If you arrive too late to be accommodated, you may be rescheduled or worked in depending upon our schedule. If you simply do not show up for your appointment, we will need to bill you a \$25.00 missed appointment fee.

**All copayments, coinsurances, deductibles, fees, and outstanding balances must be settled before seeing the physician.**

**We reserve the right to immediately cancel your care for conduct, non-cooperation or non-payment.**

Your signature represents your consent to treatment necessary for the patient named, your acknowledgement of full financial responsibility, and your understanding and acceptance of our policies detailed above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date