AVERY EYE CLINIC

YOUR VISION IS OUR FOCUS

Board-Certified Medical and Surgical Ophthalmologists
Fellows of the American Academy of Ophthalmology

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Notice to Patient: Most health insurance companies will not pay for a Complete Eye Exam with an OPHTHALMOLOGIST unless it is due to a medical illness or an injury.

Patient's Name:_____ Age:_____ Date of Birth: _____

Mailing Address:_____ City:_____ State:_____ Zip: _____

Email Address: _____

Home Phone:_____ Cell Phone: _____

Preferred Method of Contact (circle one): Home Phone Text message Email message

Patient's Social Security Number:_____ Male_____ Female _____

Spouse's Name:_____ Date of Birth: _____

Primary Care Doctor:_____ Phone: _____

Referring Doctor:_____ Phone: _____

Relative's Name (not living with you):_____ Phone:_____

IF PATIENT IS A MINOR: List the parent or guardian's name, address, and phone number below.

Name:_____ Phone: _____

Address: _____

- ❖ WE REQUIRE A COPY OF YOUR INSURANCE CARD AND PHOTO ID FOR INSURANCE PROOF.
- ❖ WE DO NOT ACCEPT WORKER'S COMP
- ❖ IT IS OUR POLICY THAT PAYMENT BE MADE AT THE TIME SERVICES ARE RENDERED.
- ❖ WE DO NOT LOOK TO A THIRD PARTY TO BILL.
- ❖ A PARENT/GUARDIAN IS RESPONSIBLE FOR ALL CHARGES FOR A MINOR CHILD. BY SIGNING BELOW, I HEREBY AUTHORIZE:

1. My consent for medical treatment by the doctor/Avery Eye Clinic Staff and acknowledge no guarantees have been made regarding the results of treatment/exam.
2. Payment from my insurance company to Avery Eye Clinic for medical treatment.
3. I understand I am responsible for all charges not paid by my insurance.
4. The release of any medical records when necessary to/from another physician, hospital or other medical facility.
5. Release of medical information to/from the insurance for claims processing.
6. I AM RESPONSIBLE IF I DID NOT OBTAIN A REFERRAL OR AUTHORIZATION FROM MY INSURANCE COMPANY OR PRIMARY CARE PHYSICIAN.
7. List the names of people to whom we may give your PRIVATE HEALTH INFORMATION:

_____

_____

_____

8. Permission to leave reminder for appointment on answering machine.

_____ _____

Patient or Guardian Signature ***Date***

Conroe
400 South Loop 336 West
Conroe, TX 77304
(936) 539-4500

Huntsville
3361 Montgomery Road.
Huntsville, TX 77340
(936) 294-0218

Woodlands
129 Vision Park Blvd., Ste. 110
The Woodlands, TX 77384
(281) 719-5214