



New Patient Forms

Patient Information

*Required Fields

Patient First Name:*

Patient Last Name:*

Date of Birth:*

Address:*

City:*

Zip Code:*

Sex:

Social Security Number:

Driver's License #:

Daytime Phone #:

Cell Phone #:*

Email:

Employer:

Occupation:

Emergency Contact:

Relation to Patient:

Phone #:

Ethnicity

- Asian
- Hispanic/Latino
- Black/African American
- White
- Other

Preferred Language

- English
- Spanish

How did you hear about us?

- Doctor Referral
 - Facebook
 - Instagram
 - Google/Internet Search
 - Friend/Patient

 - Other
-

Primary Insurance

Policy Number:

Group Number:

Policy Holder's Name:

Policy Holder's Date of Birth:

Relation to Policy Holder:

Secondary Insurance

Policy Number:

Group Number:

Policy Holder's Name:

Policy Holder's Date of Birth:

Relation to Policy Holder:

Vision Insurance

Policy Number:

Policy Holder's Name:

Policy Holder's Date of Birth:

Relation to Policy Holder:

Pharmacy of Choice:

Location:

Is there anything you would like us to know about you and your visit today?

OFFICE POLICIES

*Required Fields

APPOINTMENTS

- There is a \$50.00 no-show/late cancellation fee. All appointments must be cancelled 24 hours in advance or by 11am on Friday for a Monday appointment, to avoid charges for a no-show or late cancellation fee please call, text, or leave a voicemail at (956) 753-7373.
- I understand that my no-show/late cancellation fee must be paid before I am able to make another appointment. Rescheduling an appointment 2 or more times will be considered a no-show.
- I understand that an appointment reminder is a courtesy given to me. The responsibility to know my appointment date ultimately rests on me, the patient.

Authorization for Electronic Communication

I,

authorize Flores Eye Care Clinic to send text messages to my mobile phone number provided below for the following purposes:

- Appointment Reminders: Notifications of upcoming visits or rescheduling needs.
- Care Coordination: Follow-up instructions, prescription requests, or general health information related to my treatment.
- Flores Eye Care Clinic only sends appointment reminders via text and email. I understand that by opting out of electronic communication, I will not receive any appointment reminders or be able to communicate with staff via text or email.
- Opt-Out: I can stop receiving text messages at any time by replying STOP to any message.

- YES, I consent to receive text/email messages at the number below.
- NO, I do not wish to receive text/email messages.

Mobile Number:

Email:

Patient/Guardian Signature: _____



INSURANCE:

*Required Fields

- I certify that I have provided all the information for all insurance policies I currently have. I understand that if I withhold information regarding additional insurance policies, I will be financially responsible for all billed charges incurred for medical services. In addition, a \$60.00 insurance penalty fee will be charged for failure to provide additional insurance information.
- I understand that Flores Eye Care Clinic must follow the claim submission and prior authorization rules of all insurance policies. It is the patient's responsibility to obtain their prior authorization before being seen.
- I certify that I have completed coordination of benefits with all insurance companies I am currently enrolled in. I understand that if I am enrolled in more than one insurance company, and Medicaid is one of them, Medicaid is always the secondary insurance.

REFUNDS

- Occasionally, patients may be left with insurance credit on their account. Flores Eye Care Clinic will issue a refund due via written check within 30 days after all claims have been paid by the insurance carrier.

SPECIAL SERVICES FEE

- A service fee will apply for all non-medical services provided by our office. These services include, but are not limited to, any forms requiring a provider's signature, copies of medical records, home health reports, or any other services requiring special attention. This fee generally costs \$25.00 per form and is due at the time of request. In certain cases, this fee may be higher.

ANNUAL ROUTINE VISION EXAM

An annual routine vision exam, using your vision or medical insurance benefit, typically covers testing of visual acuity, refraction test for glasses, and general eye health assessment. If any medical issues or complaints are discussed during your Annual Routine Vision Exam, due to insurance rules and regulations, Flores Eye Care Clinic will be required to bill a medical office visit. Any co-pays, deductibles, and co-insurance will be collected at the time of service.

MEDICAL OFFICE VISIT: Refraction and Contact Lens Evaluation Policy

Refraction Fee: \$30.00 This test determines your best vision and your prescription for glasses.

Contact Lens Evaluation: Begins at \$60.00 and may be higher depending on contact lens type. This

specialized procedure determines the proper size, fit, and type of contact lenses for your eyes.

- Medicare and most medical insurance plans do not cover refractions or contact lens evaluations, classifying them as “vision” rather than “medical” services.
- If your appointment is for a medical condition, and you wish to be refracted for glasses and/or have a contact lens evaluation during your medical appointment, payment for the additional service will be charged in addition to any insurance copays and deductibles.
- Prescriptions: All fees must be paid in full before your eyeglass or contact lens prescription can be released.

By signing, you acknowledge that you understand these costs and accept financial responsibility for these non-covered services in addition to any copays, deductibles, or co-insurance due at the time of service.

Patient/GuardianSignature: _____



CONTACT LENS CLAIMS FILING

*Required Fields

- I understand and acknowledge that Flores Eye Care Clinic will not file claims to medical insurance(s) for contact lenses of any type. We will provide you with an itemized receipt (proof of purchase) that you may submit to your insurance company for direct reimbursement. Payment for contact lenses is required in full at the time of purchase. It is the patient's responsibility to understand their contact lens insurance benefits.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR CARE

1. Acknowledgment of Privacy Practices

By signing, I acknowledge that I have received and understand the Notice of Privacy Practices for Flores Eye Care Clinic, which outlines my privacy rights under HIPAA concerning my protected health information.

2. Consent for Treatment, Payment, and Health Care Operations

I consent to Flores Eye Care Clinic using and disclosing my protected health information for treatment, obtaining payment from insurance companies, and performing standard healthcare operations and assessments.

3. Patient Rights

I understand that Flores Eye Care Clinic's Notice of Privacy Practices may change and I can request a current copy at any time.

4. Designation of Others

I authorize this office to discuss my care and billing with the following individual:

Name:

Relationship:

I have read and understood this form.

Patient/Guardian Signature: _____



Name of Patient/Representative:
