

Edward R. Rashid, M.D.  
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Anhtuan Nguyen, M.D.  
Mark G. Carolan, O.D.  
George "Nick" Nicolas, Jr., O.D.  
Melanie P. Gonzalez-Oliva, O.D.

## PATIENT REGISTRATION FORM

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please Print

PATIENT NAME: \_\_\_\_\_  
(First) (Middle) (Last)

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

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

Marital Status: M \_\_\_ S \_\_\_ W \_\_\_ Social Security Number (if required by insurance): \_\_\_\_\_

Email: \_\_\_\_\_ Employer: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Referring Doctor Phone: \_\_\_\_\_

Primary Care Physician (if different from Referring Doctor): \_\_\_\_\_

PCP Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you a resident of a Skilled Nursing Facility? \_\_\_\_\_ If yes, Name of Facility: \_\_\_\_\_

### INSURANCE INFORMATION:

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

\*\*\*Policyholder: \_\_\_\_\_ Date of birth of policyholder if different from insured \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

\*\*\*Policyholder: \_\_\_\_\_ Date of birth of policyholder if different from insured \_\_\_\_\_

Vision Plan Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

\*\*\*Policyholder: \_\_\_\_\_ Date of birth of policyholder if different from insured \_\_\_\_\_

**ALL AMOUNTS DUE THAT ARE NOT COVERED BY INSURANCE WILL BE COLLECTED AT TIME OF APPOINTMENT**

### GUARANTOR OR IF PATIENT IS UNDER 18, LEGAL GUARDIAN TO COMPLETE ITEMS BELOW:

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**San Antonio (Main Office)**  
5430 Fredericksburg Road  
Suite 100  
San Antonio, TX 78229  
(210) 340-1212  
FAX (210) 340-1505

**Boerne**  
113 Falls Court  
Suite 100  
Boerne, TX 78006  
(830) 248-1222  
FAX (830) 248-1333

**Alamo Ranch**  
11345 Alamo Ranch Parkway  
Suite 201  
San Antonio, TX 78253  
(210) 617-7396  
FAX (210) 617-7383

**Kerrville**  
1446 Sidney Baker  
Kerrville, TX 78028  
(830) 792-4466  
FAX (830) 792-4640

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES & PATIENT CONSENT FORM

Our "Notice of Privacy Practices and Patient Rights" provides information about how we may use and disclose protected health information about you. The notice includes your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have a right to review the Notice before signing this consent. The terms of the Notice may change. A current copy is available on our website or by contacting our office.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. However, it is our policy to limit use of your protected health information ("PHI") to providing your medical care, to bill for our services, to collect payment from you or your insurance company, for the general operation of the business, and for certain limited statutory purposes. **We do not sell, disclose, or use your information for marketing or fundraising purposes without your prior written consent.**

Federal privacy laws now limit our ability to communicate with your family and others regarding your medical care. If you wish to grant permission for us to disclose information to others, please indicate below. You have the right to revoke this consent at any time.

**Do not disclose my information to anyone but myself**     **You may disclose information to the following:**

Name(s) \_\_\_\_\_ Relation: \_\_\_\_\_ Date: \_\_\_\_\_

By signing this form, you are acknowledging that you have been offered or provided a copy of our "Notice of Privacy Practices and Patient Rights" and consented to the disclosures above (if any).

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

## ACKNOWLEDGEMENT OF PATIENT FINANCIAL RESPONSIBILITY

I acknowledge that I am responsible for payment of any services rendered to me or my dependent. I understand the financial policies of the practice and have read or been offered a copy of the practice policies. I authorize the practice to release information necessary to process my insurance claims (to both primary and secondary insurance). I am aware a \$40 refraction fee may be charged at time of service. **\*\*\*Note: Appointments cancelled, missed or rescheduled with less than 24 hours' notice may incur a \$50 fee for office visits and/or procedures and a \$200 fee for surgery.**

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

### Notice:

1. The Physician/Owners of this practice also own Mockingbird Optical Shop and R&R Research San Antonio, TX.
2. The Physician/Owners of this practice also own a partial interest in Specialty Surgery Center and Alamo Laser Vision Center, San Antonio, TX.

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