William J. Flynn, M.D., O.D.
Gregory M. Brunin, M.D.
Anhtuan Nguyen, M.D.
Matthew Caldwell, M.D.

Eye Associates

Michael E. Offutt, M.D.
Mark G. Carolan, O.D.
Melanie P. Gonzalez-Oliva, O.D.
Teresa H. Chui, 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: _____ Daytime Phone: _____ Cell Phone: _____

Marital Status: M ___ S ___ W ___ Social Security Number (required): _____

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 use a third party "art of chat" for the sole purpose of appointment reminders (via text, phone call, or email). You have the right to opt in or out of this service. If you wish to OPT OUT, please let our front desk staff know. **We do <u>not</u> sell, disclose, or use your information for marketing or fundraising purposes without your prior written consent.**

☐ You may send reminder calls/texts for appointments ☐ Do not send reminder calls/text for appointments

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: _____ Phone: _____

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