

Insurance / Office Policy Information

Patient's Information

Patient's Name: _____ Last _____ First _____ MI _____ Gender: M / F
Patient's Relationship to Insured: _____ Spouse / Child / Self _____ Marital Status: S / M / D / W
Full Time Student: Yes / No (If Yes) Name of School: _____ State: _____
Patient's Employer/Occupation: _____
Insured's Name (If Not Self): _____ DOB: ____ / ____ / ____ Gender: M / F
Insured's Social Security #: _____ - _____ - _____ Age: _____ Marital Status: S / M / D / W
Insured's Employer: _____ Work Phone #: (____) _____ - _____
Health Ins. Company: _____ Group #: _____ Policy #: _____
Vision Insurance: _____ Group #: _____ Policy #: _____

Secondary Insured's Information

Policy Holder's Name: _____ Last _____ First _____ MI _____ DOB: ____ / ____ / ____ Gender: M / F
Policy Holder's Social Security #: _____ - _____ - _____ Age: _____ Marital Status: S / M / D / W
Insured's Employer: _____ Work Phone #: (____) _____ - _____
Secondary Ins. Comp: _____ Group #: _____ Policy #: _____

PAYMENT POLICY

All eye wear (glasses and/or contacts) must be paid in full before ordered. Any co-payments are due at the time of service. Returned NSF checks will be charged a service fee of \$32.47 or the current "State of Texas allowable".

I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.

(Signature of Patient or responsible party)

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Mario J. Contaldi, O.D.'s "Notice of Privacy Practices" to read.

(Signature of Patient or responsible party)

Date