WELCOME BACK

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name ____ Date _____________

First MI Last

If different from your last visit:

New Address ______________________________ City _______________ State _____ Zip ________

Birthdate ______________________ Main Phone ___________________________

E-mail: ____

Primary point of contact: Main Phone Work Email Text Post

Health Information:

Who is your Primary care Physician? ___________________________

List any new medical conditions since your last visit:

____
____
____
____

List any new medications since your last visit:

____
____
____
____

Are you pregnant or nursing? _________

Any changes to your use of tobacco/ alcohol since your last visit? _____________________________
____

Diabetics: When was the last time you checked your blood sugar? ____________ Results: _________

Last A1C Test _________________ Results: ___________

Reason for today's exam ____
____
____

Dr. Joshua McCown
113 N Lutterloh Ave
Gatesville, TX 76528
(254) 865-7979

PATIENT FINANCIAL POLICY STATEMENT

Dr. Joshua McCown and the staff at Vision Concepts are here to serve your visual needs as our patient. It is our goal to create a pleasant experience for our patients and avoid misunderstandings regarding financial responsibilities.

OUR RESPONSIBILITY is to assist you in understanding the provisions and limits of your insurance company and to accurately file claims in a timely manner. We will verify benefits but cannot guarantee that your insurance will pay as quoted.

YOUR RESPONSIBILITY is to be knowledgeable regarding your benefits, co-pays, and deductible and co-insurance amounts. It is ultimately the patient's responsibility for the payment of services that will/have been provided even if your insurance denies the claim or does not pay as expected. ___________ **Initial here**

I understand that it is my responsibility to call my insurance company if I have any questions regarding my benefits. ___________ **Initial here**

It is my responsibility to provide my insurance card and verify my address and phone number at each visit. If your insurance changes, please notify us immediately, because all insurance companies have a time limit to file claims. ___________ **Initial here**

I agree that I will be expected to pay my co-pay, co-insurance or any payments that are not covered by my insurance, prior to picking up your contacts or glasses.___________ **Initial here**

Your signature below indicates that you have read, understood and agree to the policy. A copy is provided upon request.

_________________________________ _______________________

Patient/Guarantor Signature Date