CLEAR LAKE EYE CENTER

Jacqueline S. Brending, O.D. | Rachel Chen, O.D.
17040 Highway 3, Webster, TX 77598
281-338-8474 (voice) 281-338-4795 (fax)

Appointment Time Today: _____ Arrival Time: _____

First Name: _____ Last Name: _____

We are now making greater use of e-mail to communicate with our patients. To help us provide the most prompt service possible, please enter your current e-mail address below:

_____

NOTE: All patient information is kept strictly confidential. Your address is NEVER shared.

If we have something important to tell you or we can't contact you otherwise, would you like a text message sent to your cellular phone?

No _____ Yes ____ Cell Phone: _____

NOTICE FOR ESTABLISHED PATIENTS

Please Initial:

_____ Clear Lake Eye Center conveniently accepts most vision insurance carriers and some medical insurance carriers. We provide high quality care and high quality materials; we want the best for you because you mean so much to us. Usually, most insurance carriers have portions of the price of the exam, frame, lens, or contacts that are not covered as part of the benefits. This portion is a co-payment; the total of the co-payment and the plan payment equal the total price for the services you receive. The co-payment is due when the service is ordered.

_____ For some services however, your plan pays only a portion of the total cost of the service you receive. For example, you might need to order contacts and the total cost exceeds the amount your plan will cover. The amount that your insurance will not cover is due when the service is ordered.

_____ Some services have no plan benefit included in the price. For these services, you must pay in full when the service is ordered.

_____ It is your responsibility to make sure Dr. Brending, or Dr. Chen, is a contracted provider with your current insurance plan before each visit. Once services have been rendered and payment has been made, we can only provide you with a detailed receipt of your visit. If you discover you have an insurance allowance at a later time, you will need to file for services through your insurance company.

_____ By signing this form, you agree that you have read this in full, and that you agree to pay the portion your insurance has mapped out in your plan benefit, your co-pay. You also agree to meet any portion of the final bill that is not covered in your plan. Finally, you agree to pay when the service is offered.

Primary Insured Name: _____

Primary Insured SSN#: _____

Primary Insured Date of Birth: _____

Patient Name: _____

Patient's Date of Birth: _____

Address: _____

City:_____ **State:** _____ **Zip Code:**_____

Home#: _____ **Mobile#:** _____

Email: _____

Patient Signature:_____

Date: _____

If Minor (Under 18 years)

Guardian Signature: _____

Date: _____

Patient's Relationship to Insured:

Self

Spouse

Child

Other

Employment Status of Patient:

Full Time

Part Time

Student

Retired

Marital Status of Patient:

S M D W