Patient Information

(This information is necessary for our files and will be considered CONFIDENTIAL)

Patient's Name_____ Spouse'sName_____

If patient is a minor, give parent's or guardian's name_____

Residence Address_____ City_____ Zip_____

Driver's License No. _____ Social Security No._____ Home Phone_____

Patient's Birth date_____ Insured Birth date_____ Cell phone _____

Employed by_____ Occupation_____

Business Address_____ Work Phone_____

Spouse Employed by_____ Occupation_____

Business Address_____ Work Phone_____

Name of nearest relative not living with you:_____ Relationship_____

Complete Address_____ Res. Phone_____

Name of Physician_____ Address_____

Purpose of this appointment_____

□ General Eye Exam □ Contact Lenses □Neuro □Low Vision □Perceptual □Consultation □Emergency □Blurred Vision

Whom may thank for referring you?_____

Financial Information

Person Responsible for this account: _____ Relationship_____

Address_____ City_____ Zip_____

Method of Payment

□ Cash on day of treatment □ Vision Insurance Co. _____ Group #_____

□ VISA #_____ Exp date_____ □ MASTERCARD_____ Exp date_____

□ DISCOVER_____ Exp date_____ □ Personal check_____

Terms & Conditions

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency vision services, or any vision services performed without prior financial arrangements, must be paid in cash at the time services are performed.

Patients who carry vision insurance understand that all vision services furnished are charged directly tothe patient and that he or she is personally responsible for payments of all vision services. This office will help prepare the patient's insurance forms once to assist in making collections from insurance companies aand will credit such collections to the patient's account. However, this vision office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimate listed for this vision visit can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and / or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered or within five (5) days of billing if credit shall be extended. I further agree that any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all coasts and reasonable attorney fees if suit be institute hereunder.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions to treatment and agree to their content.

Signed:_____ Date_____