Welcome To Our Office!

o Mr.
o Mrs.
o Miss
o Ms.
o Dr.

First Name **Middle** **Last Name**

Address **City** **Zipcode**

Day / CELL Phone **HOME Phone**

Preferred Name **Birthdate** **Social Security #**

Guardian/Account Responsibility **Guardian Phone**

E-MAIL ADDRESS ____________________________________

VISION Insurance: Primary/2nd

Member Name:

Member ID # and Date of BIrth

MEDICAL Insurance

Member Name:

Member ID # and Date of BIrth

How did you select our office?

o walk-in o internet o family comes here o insurance list o doctor referral____________________
o referred by___________________ o other_______________________

Office Policy - Please Read

- Most insurance policies pay only a portion of total charges. Questions about coverage should be directed to the appropriate insurance/benefits representative. Coverage information provided by the insurance company should be used as an outline only, *we cannot guarantee its accuracy*.
  Final financial responsibility is the patient's, not the insurance company's.
- In certain situations we may file forms for select types of insurance so that the patient may obtain direct reimbursement, *but he or she will still be responsible for all charges incurred*.
- **Important for contact lens wearers:** Some contact lens related items and services may not be completely or even partially covered by insurance benefits. For example, the *Contact Lens Evaluation* which is part of a complete *Annual Contact Lens Examination* is not covered by most insurance examination coverage. Contact lens fittings may also not be covered.
- In addition, contact lens prescriptions for new contact lens wearers will only be released to patients after the mandatory Contact Lens Evaluation and Fitting and only after a period of three to six months (at the doctor's discretion) to finalize the accuracy of the prescription.

I have read and agree to abide by office policy. I understand that payment is expected at the time services are rendered, and that I may be asked to pay a deposit on ordered items.

Patient Signature____ **Date** __________