PATIENT INFORMATION

(Please Print Neatly) Today's Date: _____

Patient's Legal Name: _____ Birth Date: _____
(First) (MI) (Last)

Address: _____
(Street) (City) (State) (Zip)

Phone: (H)_____; (C)_____; (W)_____
Allow Text Message? ___ YES ___ NO

e-Mail Address: _____; Patient SSN: _____

Occupation or Grade _____ Employer or School _____

Patient's Family Member(s) Names (living in household): Spouse Name: _____

Children or Siblings (living at home)_____

Child's Mother's Name: _____; Child's Father's Name: _____

Who should we contact in the event of an emergency? _____

Relationship (spouse, sister, neighbor, etc.) _____ Phone: _____

Whom may we thank for referring you to us? _____

Our Financial Policies

1. We accept cash, personal first party checks, VISA, Mastercard, and Discover.
2. Professional service fees and insurance Co-Pays are due on the day of service.
3. Eyeglass fees may be paid in full at the time of order or may be paid as 50% at the time of order and the balance on delivery.
4. Contact lens charges must be paid in full at dispensing.
5. Insurance copays and additional charges for "extras" are due at the time of order.
6. Patients must supply us with all necessary billing information and forms on the day of service.
7. Amounts unpaid by insurance must be paid immediately upon the receipt of a statement from us.
8. A $10.00 fee will be added to each additional statement we must prepare and send out.
9. Checks returned for lack of funds are subject to $20.00 returned check fee plus any recovery costs.
10. Outstanding accounts over 90 days will be subject to collection action.
11. Adults bringing minors for service and/or materials are personally responsible for payment.
12. Questions about our Privacy Policies or Financial concerns may be directed to Richard Eric Strain.

Should we contact someone other than the patient to discuss financial issues? YES „ NO „

Who?_____ Daytime phone: _____ Best time to call: _____

I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations. I acknowledge the receipt of the Notice of Privacy Practices of this office and I understand it. Further, I understand that I am responsible for all charges whether or not they are covered by insurance.

_____ _____
Signature of Patient / Personal Representative Date

Relationship to Patient: Self Parent Legal Guardian (Circle one)