

Allisonville Eye Care Center, Inc.

Patient Information

Patient Name Miss.
Ms.
Mrs.
Mr.
Dr. _____
First Middle Last Preferred Name

Date of Birth ____/____/____ Social Security Number ____-____-____

Male ____ Female ____ Marital Status: (circle) Single Married Divorced Widowed

Address _____
Apt. City State Zip Code

Phone Numbers: Hm ____-____-____ Wk ____-____-____ Cell ____-____-____

Email Address (for possible Contact) : _____

Employer _____ Occupation _____

Primary Care Physician:

Name

Address
Telephone _____

Other Specialists/Physicians:

Name

Address
Telephone _____

Guarantor Information

Guarantor Name _____
First Middle Last

Date of Birth ____/____/____ Social Security Number ____-____-____

Relationship to the Patient _____

Insurance Information

(Please fill out as much information as you can)

Primary Vision Insurance (Please circle) VSP VCP SPECTERA EYEMED OTHER _____

Policy Holder Name _____ Social Security Number ____-____-____

Medical Insurance _____

Policy Holder Name : _____ D.O.B. ____/____/____ SSN: ____-____-____

Policy Number # _____ Co-Pay\$ _____ Deductible\$ _____

Employer _____

Relationship to Patient _____ Eligibility Date _____

Please list other family members living at home who have not had a recent eye exam:

How did you hear about our office? _____

Financial Policies

Co-payments and fees not covered by your insurance are due upon date of service. We will file claims for services rendered to the appropriate insurance payer in good faith. All medical eyecare is subject to any insurance deductible. It is the patients responsibility to know the specifics of the insurance plan and to pay any amounts applied to the patient deductible. A minimum **50% DOWN PAYMENT** on materials is required to start your order. Any balance will be due upon dispensing of your eyewear. Unpaid balances are subject to monthly late fees and additional service fees if sent to collections. **NO CASH REFUNDS ON MATERIALS.**

Insurance Authorization

I have read and understand the above Policies and authorize payment of insurance benefits from Medicare, Medigap, or other insurance companies to be made on my behalf for any Optometric services rendered. I also authorize Allisonville Eye Care Center, Inc. to release any information needed to the appropriate agency to determine any benefits and provide appropriate care.

SIGNATURE (RESPONSIBLE PARTY) _____ **DATE** ____/____/____

Printed name of Responsible Party _____

Notice of Privacy Policy

By signing below, I indicate that I have received a copy of the Notice of Privacy Practices of Allisonville Eye Care Center, Inc. (This can be printed from our web site in advance (www.all-eyes.org) or obtained upon arrival at the office.)

SIGNATURE (RESPONSIBLE PARTY) _____ **DATE** ____/____/____