



PATIENT INFORMATION

Mr. Mrs. Miss Ms. Child Single Married Divorced Widowed Male Female

Name: _____
(Last) (First Name) (Middle Initial)

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

Email Address: _____

Birthdate: _____

Employer: _____ Occupation: _____

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

Home Phone: (_____) _____ Work Phone: (_____) _____

PERSON RESPONSIBLE FOR ACCOUNT

(Complete only if a different person than listed above)

Completed by: Parent Custodian Guardian

Name: _____
(Last) (First Name) (Middle Initial)

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

Email Address: _____

Birthdate: _____ Social Security No.: _____

Employer: _____ Occupation: _____

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

Home Phone: (_____) _____ Work Phone: (_____) _____

IF THIS APPOINTMENT IS FOR A CHILD Yes No

School that he / she attends: _____ Full Time Part Time

WHOM MAY WE THANK FOR REFERRING YOU TO STINE EYE CENTER?

Name: _____

Address: _____

If not referred, how did you hear about us? _____

Today's Date _____

INSURANCE INFORMATION

PRIMARY CARRIER: Medical Vision Benefits - Examinations Vision Benefits - Glasses, Contacts

Insurance Company: _____

Employee / Subscriber: _____ Employer: _____

Birthdate: _____

Maximum Yearly Benefit: _____ Deductible: _____

SECONDARY CARRIER: Medical Vision Benefits - Examinations Vision Benefits - Glasses, Contacts

Insurance Company: _____

Employee / Subscriber: _____ Employer: _____

Birthdate: _____

Maximum Yearly Benefit: _____ Deductible: _____

IF ADDITIONAL CARRIERS PLEASE NOTIFY US...

Do you participate in a Flexible Spending Account? Yes No

PAYMENT POLICIES

EYEWEAR

A 50% downpayment is required on all eyewear purchases with the remaining balance to be paid at dispensing. Any order failed to be picked up within 30 days of its order date, will be returned and the patient will be charged a 30% restocking fee.

CONTACT LENSES

Because contact lenses are a controlled prescription device, all orders must be paid for at the time of ordering. Any order failed to be picked up within 30 days of its order date, will be returned and the patient will be charged a 15% restocking fee

VISION AND HEALTH SERVICES

Payment in full is expected at the time service and care are given. If you have vision or health insurance, we will submit a claim to your insurance company for you. The balance on your account will remain your responsibility. We expect payment in full within 60 days, regardless of insurance pending. Any account with a balance over 60 days, with no arrangements made, will be charged a finance charge and may be sent to a collection agency.

RELEASE

I authorize the eye doctor to release any information including the diagnosis and treatment rendered to me or my dependents during the period of such eyecare to third party payers, patient employers and/or health practitioners, as well as those listed below. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my insurance carrier(s) may pay less than the total bill for services. I agree to be responsible for payment of all services/products rendered on my behalf or my dependents, regardless of insurance benefits. I also understand that a monthly 1½% or \$2.00 minimum financial charge (18% annually) may be added to any account balance over 60 days old and may be sent to a collection agency.

My preferred method of payment will be Cash Check Charge

Names of those to whom my health and account information can be released to:

_____ Relationship: _____

_____ Relationship: _____

X _____
Signature of Responsible Party

Date: _____