Eye & Vision

The information is confidential and only used for office purposes such as notices, recalls, confirming appointments and passwords to order contact lenses online. This information will never be shared.

Mr. Mrs. Ms. Dr.

First Name **MI** **Last Name**

Address:

Apt:

City: **State** **Zip**

Date of Birth: **MM/DD/Yr.**	**Age:**	**Gender:** **M F**

Email:

Phone:

Cell Phone:

Employer	
Occupation	

IMPORTANT INSURANCE NFORMATION:

Your vision plan is intended for "eyeglasses or contact lens" exams. This is limited to your prescription, and a screening for eye disorders. *Vision Plans do not cover* medical eye care (floaters, dry eyes, allergy, lazy eye, Vision loss, red eyes, infections and such) or any prescription for Medication.

If you have a pre-existing condition or any disease that affects vision or can cause blindness (cataracts, glaucoma, dry eye, diabetes, high Blood Pressure, cholesterol, etc.) Then your exam will be considered medical Care. These services will be covered by your major medical Insurance. Vision plans do not cover medical eye care.

At the time of Service we require both insurance information.

HIPAA & PRIVACY:

_____***I have read or been presented with the HIPAA Privacy Policy manual and wish to continue care.***

Person responsible for Account:	**Relationship:** Parent Child Self Spouse

Name:

Please let us know how you where referred:

_ Friend Family _ Mail _Advertisement _ Internet Search _ Insurance

Other:_____

Insurance and Vision Plan information:

MEDICAL INSURANCE:	
Employer	

Insured Name:

Relationship: Circle one: Self Spouse Child Other

Ins ID#: _____ Group# _____

Ins SS# _____-_____-_____ DOB _____/_____/_____

Insurance Phone Number ( ) --

OPTICAL - Vision PLAN:	
Employer	

Insured Name:

Relationship: Circle one: Self Spouse Child Other

Ins ID#: _____ Group# _____

Ins SS# _____-_____-_____ DOB _____/_____/_____

Insurance Phone Number ( ) --

Insurance:		

- If you do not WRITE DOWN you have Medical Coverage or Vision Plan before service or goods are rendered, we will assume no coverage exists. Our Office with NO EXCEPTIONS will not back file claims, post authorize claims or refund.
- If you discover you have Medical or Vision coverage after professional services or products are rendered, it is your responsibility to file your claim for reimbursement. We will help you file your claim.

I have read and understand the terms and policies of Eye and Vision and allow Eye and Vision Management to file for Insurance payments or collect payment. I certify that the information supplied on this statement Is accurate to the best of my knowledge.

Signed: Date

Please do not hesitate to ask if you have any questions