optomeyes
AN OPTOMETRIC CENTER

PATIENT INFORMATION

Please print clearly

LAST NAME	FIRST NAME	NICKNAME	TITLE	SEX	DATE OF BIRTH	AGE

STREET ADDRESS (No PO Box Addresses)	APT#	CITY	STATE	ZIP

HOME#	CELL#	WORK#	EXT	EMAIL

OCCUPATION	EMPLOYER	LAST EXAM	REASON FOR VISIT	REFERRED BY

SS# - -	PARENT/GUARDIAN (If patient is under 18)

INSURANCE INFORMATION	DO YOU HAVE A HEALTHCARE OR FLEX SPENDING ACCOUNT? YES NO

I UNDERSTAND THAT A ROUTINE EYE EXAMINATION DOES **NOT** INCLUDE A CONTACT LENS EVALUATION AND/OR FITTING AND ADDITIONAL FEES WILL APPLY FOR THOSE SERVICES.

I UNDERSTAND THAT EXAMINATION FEES AND DEDUCTIBLES ARE TO BE PAID IN FULL ON THE DAY OF THE EXAMINATION AND ALL ORDERS ON GLASSES AND/OR CONTACT LENSES REQUIRE A MINIMUM DEPOSIT OF 50%.

I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES AND GOODS NOT COVERED BY MY INSURANCE.

I UNDERSTAND THAT IF MY CHECK IS RETURNED FROM THE BANK, A $35.00 SERVICE CHARGE WILL BE ADDED TO MY ACCOUNT.

I UNDERSTAND THAT IF I DEFAULT ON PAYMENT AND MY ACCOUNT GOES TO COLLECTION I WILL BE RESPONSIBLE FOR COLLECTION FEES, LEGAL FEES ASSOCIATED WITH RECOVERY AND INTEREST ON THE OUTSTANDING BALANCE.

I AUTHORIZE THE RELEASE OF INFORMATION TO MY INSURANCE COMPANY NECESSARY TO PROCESS THIS OR OTHER CLAIMS. I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE TO **DR LES MILLER/OPTOMEYES** FOR ANY SERVICES FURNISHED TO ME.

_____ _____

Signature Date

ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practices. I can receive a copy of this notice upon request.

_____ _____

Signature Date