optomeyes

AN OPTOMETRIC CENTER

Please print clearly

PATIENT INFORMATION

LAST NAME	FIRST NAME	TITLE	SEX	BIRTHDATE	AGE

STREET ADDRESS:	APT #	CITY	STATE	ZIP

EMAIL:	CELL #	WORK #

OCCUPATION	EMPLOYER	LAST EXAM	REASON FOR VISIT	REFERRED BY

SS#:	PARENT/GARDIAN (If patient is under 18):

INSURANCE INFORMATION: Medical/Primary Eyecare Plan	DO YOU HAVE A FSA/HSA ACCOUNT Y N

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

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of optomeyes' Notice of Privacy Practices.

_____ _____

Signature Date

EXAMINATION FEES AND ANY DEDUCTABLES 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%.

THERE WILL BE A CHARGE OF $45.00 ON ALL RETURNED CHECKS AND CHARGEBACKS

AN INTEREST FEE OF 1 1/2 % PER MONTH (18% PER YEAR) WILL BE CHARGED TO ACCOUNT BALANCES PAST 30 DAYS.

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

WE HAVE A NO REFUND POLICY ON NON PRESCRIPTION SUNGLASSES AND CUSTOM ORDERED SPECTACLE LENSES.

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Signature Date

1513 4th STREET, SANTA MONICA, CA 90401
TEL: (310) 260 1000 FAX: (310) 260 1002