VISION CARE CLINIC

To better care for your needs, please complete the following information as accurately as possible.
All information is kept confidential. It is our pleasure to care for you!

PATIENT INFORMATION

Date _____/_____/_____

Last Name_____ First Name_____ MI ___ Nickname _____

Address _____Apt.#_____City_____State _____Zip_____

SSN_____-_____-_____ DOB _____/_____/_____ Email address_____

Home Ph _____ Cell Ph _____ Work Phone _____
*If you have included a cell phone, you are giving our office or assignee permission to call that phone

Please circle: Male/Female Married/Single/Divorced/Partner/Child Preferred Language/Ethnicity_____

Emergency Contact Name_____ Emergency Phone Number_____

Person responsible for bill (if over 18 patient is responsible):

Full Name _____ DOB _____/_____/_____ SSN_____-_____-_____

Employer_____ Phone Number_____

FINANCIAL INFORMATION

Payment for services is required at the time of service. Please indicate how you intend to pay for your professional fees and/or materials not covered by any insurance: Cash Check Visa MasterCard Discover AMEX Care Credit

We accept Care Credit. Apply at www.carecredit.com

PRIMARY INSURANCE

Primary insured's name _____ Relationship to patient _____

Primary insured's DOB _____/_____/_____ Primary insured's SSN _____-_____-_____

Employer _____ Occupation _____ Phone _____

Name of insurance _____

Subscriber ID _____ Group Number _____

Address if different from patient _____

SECONDARY INSURANCE (IF APPLICABLE)

Secondary insured's name _____ Relationship to patient _____

Secondary insured's DOB _____/_____/_____ Secondary insured's SSN _____-_____-_____

Employer _____ Occupation _____ Phone _____

Name of insurance _____

Subscriber ID _____ Group Number _____

Address if different from patient _____

Please present your card(s) for our records and billing purposes.

Account #: _____ **(Please complete other side)**

Patients with Tricare:
I understand that I am financially responsible for charges for services which are not covered by Tricare. I understand that Tricare does not pay for routine contact lens services.

Signed: _____ Date: _____

Patients with Medicaid/BCBS/HELP/TPA:

I understand that I am financially responsible for charges for services which are not covered by the insurances listed above. I understand that routine contact lens services are not covered. I understand that I may order glasses outside of my insurance for which I will be financially responsible.

Signed: _____ Date: _____

Consent for treatment: I consent to treatment deemed advisable by Dr. Robert Sherer. I understand further testing and follow-up appointments for treatment and diagnosis may result in additional fees.

Authorization for the Release of Medical Information: I hereby authorize Vision Care Clinic to release all information necessary to secure the payment of benefits.

Assignment of Benefits: I assign directly to Vision Care Clinic all vision/medical benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature: I authorize the use of this signature on all my insurance submissions.

Notice of Privacy Practices: I have read and/or reviewed the notice of privacy practices made available by Vision Care Clinic.

All authorizations remain in effect until revoked in writing by either party.

Signed:_____Date:_____

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Revised: 01/08/2018