PATIENT INFORMATION FORM OPTICARE

NAME: RELATIONSHIP TO PATIENT: CELL NUMBER:	PATIENT NAME:		
PARENT/GUARDIAN: NAME: RELATIONSHIP TO PATIENT: CELL NUMBER: E-MAIL ADDRESS: SOCIAL SECURITY NUMBER: F-YOU HAVE INSURANCE THAT COVERS EYE EXAMS OR ANY MATERIALS YOU MAY RECEIVE FROM OUR OFFICE, WE ARE PLEASED TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. PROVIDE US WITH YOUR INSURANCE ID CARD. AND WE WILL BE HAPPY TO HELP YOU PROCESS YOUR INSURANCE CLAIMS FOR REMBURSEMENT. IF YOU HAVE NO INSURANCE CLAIMS IS A COURTESY WE EXTEND TO OUR PATIENTS, ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY. IF YOU HAVE NO INSURANCE ID CARD YOU ARE RESPONSIBLE TO PAY FOR YOUR SERVICES THE DAY THEY ARE RECEIVED. PLEASE ASK IF YOU HAVE QUESTIONS ABOUT THE ABOVE INFORMATION. WE ARE HERE TO HELP YOU! PAYMENT FOR ALL SERVICES IS DUE ON THE DATE OF SERVICE. HOW WILL YOU BE PAYING TODAY FOR SERVICES AND/OR MATERIALS NOT FILED TO INSURANCE? PLEASE CIRCLE ONE: CASH * CHECK * CREDIT CARD PLEASE READ AND SIGN: IAUTHORIZE AND REQUEST OPTOMETRIC TREATMENT/SERVICES AND APPLICABLE FOLLOW UP CARE FOR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY FINANCIAL OBLIGATION INCURRED FOR THE OPTOMETRIC SERVICES FOR THE OPTOMETRIC OF THE OPTOMETRIC	CELL PHONE:	E-MAIL ADDRESS:	
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(Rev 4 PATIENT INFO FORM EGF-CRK 09-23-20)