Eldred Eye Center
Patient information

Today's Date:_____/_____/_____

PATIENT INFORMATION

LAST:_____ MI: _____FIRST: _____

DATE OF BIRTH _____/_____/_____ SSN_____ SEX: MALE/FEMALE

ADDRESS: _____ CITY: _____ STATE:_____ ZIP: _____

HOME #: (_____) _____-_____ CELL#:(_____) _____-_____ Would you like to receive text reminders? YES NO

EMAIL: _____ I DO NOT WANT MY E-MAIL ADDRESS ON FILE. I DECLINE _____

Race:
- Alaska Native or American Indian
- Asian
- Black/African American
- Hispanic
- Native Hawaiian
- White

Ethnicity:
- Native-Hawaiian/Pacific Islander
- Hispanic or Latino
- Not Hispanic or Latino

Preferred language
- English
- Spanish

PERSON RESPONSIBLE FOR ACCOUNT

LAST:_____MI:_____FIRST:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP_____

DATE OF BIRTH ____/____/_____ SSN_____

HOME #(_____)_____-_____ CELL # (_____)_____-_____ WORK# (_____)_____-_____

Employer: _____

INSURANCE

Vision Insurance Company (Check Which Apply): ☐None ☐VSP ☐EyeMed ☐Medicaid ☐BCBS ☐Tricare ☐Medicare

☐Other_____ Subscriber DOB____/____/_____

ID#/SSN_____ Group#_____

Subscriber Name_____ Relationship to Patient: ☐Self ☐Parent ☐Spouse

EMERGENCY CONTACT/RELEASE OF MEDICAL INFORMATION

LAST:_____ MI:_____FIRST:_____

RELATION_____ HOME#(____)_____-_____ CELL#(_____)_____-_____

ADDRESS_____

CITY_____STATE_____ ZIP CODE_____

Please see reverse side for our policies

Payment and / or Co-Payment are expected at the time of your visit unless other arrangements have been made. We accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit. If you do not carry insurance, or if your coverage is currently under a pre-existing clause, payment in full is expected at the time of your visit.

A prompt/self-pay discount of 25% is applied to exam services and eyeglasses when payment is received in full.

Insurance: We are participating providers with multiple insurance plans. As a courtesy, we will file these insurance claims. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits you were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

You are responsible for giving Eldred Eye Center **current** insurance ID numbers and personal information. The patient is responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event you're insurance plan determines a service is "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Collection Status: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. Including a charge of 7% interest per month on all past due obligations.

Returned checks: will incur a $30.00 service charge. You will be asked to bring in cash, certified check, money order or credit card to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services or materials from our clinic. All "bad" checks and unpaid balances written to this office are subject to collections

Cancellations or missed appointments: If you do not cancel your appointment at least 24 hours before, or if you no-show, we may assess you a $25 missed appointment fee. This is at the discretion of Eldred Eye Center.

Responsibility for payment: I understand that I, personally, am financially responsible to Eldred Eye Center for charges not covered by the assignment of insurance.

Release of information: I hereby authorize Dr. David Eldred/Eldred Eye Center Of Cheyenne P.C. to release to government agencies, insurance carriers, or others who are financially liable for such professional and medical are, all information needed to substantiate claim and payment.

Name (Please print)_____

Signature_____ Date_____

Relationship to Patient_____