Welcome to Greencastle Eye Care Center, Inc.

Date: _____

Name: _____ Date of Birth: _____

Address: _____
City State Zip

Email: _____ Phone: _____

Work Phone: _____ Cell: _____

Which phone number do you prefer that we use to contact you?_____

Sex: M or F Age: _____ Race: _____ Occupation: _____

SSN: _____ Parent/Spouse Name: _____

May we discuss your case with your parent/spouse: Y or N P/S Phone:_____

Emergency contact other than spouse: _____ Phone:_____

Emergency Contact Relationship: _____

How did you hear about our office: _____

There are two types of insurance that will help you pay for your eye care services and optical products. You may have both types, such as: medical insurance (Blue Cross, Blue Shield, Medicare, etc.) and/or vision plans (VSP, EyeMed, Davis Vision, etc.)

- Medical insurance must be used for medical eye care. This will be determined by the doctor and billed in accordance with insurance regulations.
- If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other. We will follow proper procedures set by the insurance companies and bill accordingly.
- If fees are not paid by your insurance, such as: deductibles, co-pays, non-covered services, etc., we will bill you for them as allowed by the insurance contract.

Please provide your insurance cards to our staff member. We need to have your medical insurance or Medicare card on file to bill your insurance.

Payment is expected when services are rendered, including non-covered portions of insurance. If we do not participate with your insurance plan, we expect payment in full and will provide an itemized receipt for you to submit to your insurance company for reimbursement. We do not guarantee reimbursement or accuracy of information given to us by the insurance company.
I understand and agree that financial responsibility for my account is mine and not that of the insurance company.

I understand that all accounts with a balance over 30 days will be assessed a 1.5% late charge per month on the unpaid balance.
If my account becomes assigned to a collection agency, I agree to pay a collection agency fee of 25%, interest in the amount of 18%, court cost, and attorney fees as allowed by law.

Communications With You: You agree that we, our agents or assignees may: call by telephone regarding your account, place such calls using an automatic dialing announcing device, make such calls to any telephone numbers you have provided including mobile or similar device, and for training purposes or to evaluate the quality of service, may listen to and/or record phone conversations.

By signing below, I acknowledge and accept the office payment policy and hereby grant permission for Greencastle Eye Care Center, Inc., and any other practitioner involved in my care to exchange information concerning my case. I also acknowledge that I am aware of, and was able to receive a copy of, the Greencastle Eye Care Center, Inc. Notice of Privacy Practices.

_____ _____
Signature of Patient or Guardian (SEAL) Date