# Welcome To Our Office

Date:______________________

Name:________________________________ Email Address: ______________________

Telephone: ______________ ______________ ______________
Home Office Cell

______________________ ______________ ______ ______________
Address City State Zip

Sex: M F Birth:____-____-____ Race:__________ Occupation: ______________________ Age:______

Social Security #: ________-________-________ Hobbies ______________________________

❑ Parent or ❑ spouse's name: ______________________________ Phone:____________

May we discuss your case with your parent or spouse? ❑ Yes ❑ No

Emergency contact other than spouse: ________________ Relationship:__________ Phone:____________

Date of last eye examination:______________ by Dr.: ______________________________

Family physician: ______________________ Phone # ____________ Last health exam date: __________

How did you hear about this office? ______________________________________________

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

- Medical insurance must be used for medical eye care. This will be determined by the Doctor, 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 to bill appropriately.
- If some fees are not paid by your insurance, we will bill you for them, such as: deductibles, co-pays, non-covered services, etc. 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 for billing 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 give you an itemized receipt for you to submit for reimbursement. We do not guarantee reimbursement or accuracy of information given to us by the insurance company. Please understand that financial responsibility for your account is yours, not your insurance company.

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, Greencastle Eye Care Center, Inc., Notice of Privacy Practices.

______________________________________ Date:______________
Patient Signature or Guardian