Stine Eye Center
EYE CARE & EYE WEAR

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Male ☐ Female

Name: _____
(Last) (First Name) (Middle Initial)

Mailing Address: _____
(Street) (City) (State) (Zip)

Email Address: _____ May we email you regarding: Appointments? Yes No
Promotions? Yes No

Birthdate: _____

Employer: _____ Occupation: _____

Employer Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ May we text you regarding: Appointments? Yes No
Promotions? Yes No

PERSON RESPONSIBLE FOR ACCOUNT

(Complete only if a different person than listed above)

Completed by: ☐ Parent ☐ Custodian ☐ Guardian

Name: _____
(Last) (First Name) (Middle Initial)

Mailing Address: _____
(Street) (City) (State) (Zip)

Email Address: _____

Birthdate: _____ Social Security No.: _____

Employer: _____ Occupation: _____

Employer Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____ Work Phone: (_____) _____

IF THIS APPOINTMENT IS FOR A CHILD ☐ Yes ☐ No

School that he / she attends: _____ ☐ Full Time ☐ Part Time

WHOM MAY WE THANK FOR REFERRING YOU TO STINE EYE CENTER?

Name: _____

Address: _____

If not referred, how did you hear about us? _____

Today's Date _____

INSURANCE INFORMATION

There are two types of vision health insurance that may help pay for your eye care services and optical products. You may have both types: 1) Vision plans (such as VSP, EyeMed and others) and 2) Medical Insurance (such as Blue Cross/Blue Shield, Medicare and others).

• Vision plans only cover routine vision wellness exams, and possibly a portion of your eyeglasses and contact lenses. The portion they pay will depend on whether you are in-network or out-of-network and what product you choose. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).

• Medical insurance must be used for medical eye care.

• If you have both types of insurance plans it may be necessary to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.

• It is the patients responsibility to understand their insurance benefits and whether we are in or out of their network.

• If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as defined by the insurance contract. If we are an out-of-network provider on your plan, we will give you the necessary paperwork for you to submit for reimbursement.

Please provide your insurance cards to our staff member so we can make a copy.

Do you participate in a Flexible Spending or Health Savings Account? ☐ Yes ☐ No

PAYMENT POLICIES

EYEWEAR

A 50% downpayment is required on all eyewear purchases with the remaining balance to be paid at dispensing. Any order failed to be picked up within 30 days of its order date, will be returned and the patient will be charged a 30% restocking fee.

CONTACT LENSES

Because contact lenses are a controlled prescription device, all orders must be paid for at the time of ordering. Any order failed to be picked up within 30 days of its order date, will be returned and the patient will be charged a 15% restocking fee

VISION AND HEALTH SERVICES

Payment in full is expected at the time service and care are given. If you have vision or health insurance, we will submit a claim to your insurance company for you as a courtesy. The balance on your account will remain your responsibility. We expect payment in full within 60 days, regardless of insurance pending. Any account with a balance over 60 days, with no arrangements made, will be charged a finance charge and may be sent to a collection agency.

RELEASE

I authorize the eye doctor to release any information including the diagnosis and treatment rendered to me or my dependents during the period of such eyecare to third party payers, patient employers and/or health practitioners, as well as those listed below. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my insurance carrier(s) may pay less than the total bill for services. I agree to be responsible for payment of all services/products rendered on my behalf or my dependents, regardless of insurance benefits. I also understand that a monthly 1½% or $2.00 minimum financial charge (18% annually) may be added to any account balance over 60 days old and may be sent to a collection agency.

My preferred method of payment will be ☐ Cash ☐ Check ☐ Charge ☐ Care Credit

Names of those to whom my health and account information can be released to:

_____ Relationship: _____

_____ Relationship: _____

X_____ Date: _____

Signature of Responsible Party