DOUGLAS FAMILY EYECARE, INC.

Explanation of Vision and Medical Services

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____State: _____Zip: _____

Phone #'s: Home: _____ Cell: _____ Text: y or n (circle)_____

Primary Vision Insurance: _____ Subscriber's Name: _____

Subscriber's DOB: _____Soc. Sec. # :_____Group #/ID #: _____

Secondary Ins.: _____ Subscriber's Name/DOB/ Soc. Sec. #: _____

_____Group#/ID #: _____

Spouse/Partner/Parent (Guarantor w/ Insurance) please circle

Last Name: _____ M. Initial: ____ First: _____DOB: _____

Address if differs from patient: _____

Home phone #: _____ Cell #: _____

Can we leave a message? ____ Home ____Cell (Please check)

Immediate Family Members of Patient: _____

_____

Douglas Family Eyecare, Inc. provides both medical and vision services to their patients. Services will be billed to the patient's medical and /or vision insurance company depending on the doctor's diagnosis on the date of service. Medical conditions dictate which insurance must be billed.

It is the patient's responsibility to know what their insurance covers, what their co-pays and deductibles are, and what they are eligible for on the date of service.

Billing an insurance company does not guarantee that payment will be received for the services rendered. Insurance companies may take several months to process claims. Therefore, patients may not be billed for any balance due for several months. Any insurance co-pays, deductibles, or non-covered services are the responsibility of the patient.

I understand that I am financially responsible for charges if uninsured or not covered by my insurance.

_____ _____

Signature Please **Print** Name

I acknowledge that I have read the Douglas Family Eyecare Notice of Privacy Practices.

Sign: _____ Date: _____