

205-678-2565

		PERSONA	LINFORMA	ATION			
DATE	DATE OF BIRTH/	_/ AG	E SS#	#			
name □dr□mr.□mrs.I	MS		MIDDLE		LAST		
HOME ADDRESS			HOME PHONE	#			-
CITY	STATE	_ ZIP	WORK PHONE	#	CELL F	PHONE#	_
OCCUPATION		_EMPLOYER/SC	CHOOL				_
GUARDIAN (IF UNDER 18)		_ RELATIONSHIP				_	
ADDRESS (IF DIFFERENT)		CITY		_ STATE	ZIP	_	
E-MAIL							

Please specify the best method to receive patient notifications (reminder of appointments, notification that glasses or contacts are ready for pick up and Chelsea Eye Care News Updates.) Denne Email Text Message

HOW DID YOU FIND OUT ABOUT CHELSEA EYE CARE? YELLOW PAGES RADIO INSURANCE KEBSITE FAMILY FRIEND

WHOM SHOULD WE THANK FOR REFERRAL?

INSURANCE INFORMATION

PRIMARY INSURANCE	MEMBER#
PERSON INSURED	_ DATE OF BIRTH// GROUP#
RELATIONSHIP TO PATIENT	_SECONDARY INSURANCE
MEMBER ID#	

SIGNATURE ON FILE

I hereby authorize payment of Medicare and/or Medigap, or other health insurance benefits to Hartley Nichols Eye Care, LLC for professional services rendered. I authorize the release of any necessary medical information, including copies of medical records, for determination of payment of benefits. I understand Dr. Nichols accepts assignment for Medicare, Blue Cross, and certain other HMOs and PPOs with which he is affiliated, and that I am responsible for any deductions, co-pays and/or fees for non-covered services such as office visits, without required referral, refraction fees, non-medically related office visits, deluxe frames not covered by any insurance/vision plan (when applicable) and contact lens fitting fees,

RESPONSIBLE PARTY'S SIGNATURE

FINANCIAL POLICY

If you have insurance with which we are unfamiliar, or that we know from experience will not pay benefits directly to us, the undersigned will be responsible for fees for services rendered, and we will gladly file your insurance for reimbursement to you. However, it is the undersigned's responsibility to handle any and all problems that arise with your insurance company. Again, we are happy to re-file any claims per the undersigned's request after the insurance company has been contacted to verify that re-filing is necessary.

Chelsea Eye Care cannot guarantee anything about the undersigned's insurance as the contract is between the undersigned and their Insurance company, not with this office. We will assist in any way possible, but it is the responsibility of the undersigned to know their insurance. The undersigned is responsible for obtaining referrals when necessary.

If a balance remains on the account after 90 (ninety) days, a 1.5 % late fee will be added monthly to the unpaid balance. There is a \$30 returned check fee.

A fifty percent deposit is required on all eyewear. Full payment is due on all contacts when an order is placed.

I HAVE READ AND UNDERSTAND THE ABOVE STATED FINANCIAL POLICY AND AGREE TO ALL CONDITIONS. I ALSO AGREE THAT IN THE UNUSUAL EVENT THAT MY ACCOUNT BECOMES DELINQUENT, I WILL PAY ANY COLLECTION FEES REQUIRED TO SETTLE MY ACCOUNT.

DATE