

Spectrum Optometry

Last Name _____ First Name _____ AKA _____ Birth Date ___-___-___ M / F

Address _____ City _____ State ___ Zip _____ Language Preference _____

Cell# () _____ - _____ Home# () _____ - _____ Work# () _____ - _____ x _____

Occupation _____ Employer/ School _____ e-mail: _____

Primary Insurance Co. _____ Additional/ Medical Insurance Co. _____ Card Present Y / N

Primary Insured's SSN /ID _____ Relationship to Primary Insured: Self Spouse Child Other

Primary Insured: Last name _____ First name _____ Primary's Birth Date ___-___-___

Spouse or Legal Guardian

Last _____ First _____ Relationship _____ Birth Date ___-___-___ M / F

HOW DID YOU FIND US?

Ads Flyer Internet TV Yellow Pages Insurance Walk-in Friend. Referred by

Ask about our popular no interest Payment Method: ask about CareCredit* !! *Subject to credit approval

Office Policy

I've hereby been informed that Spectrum Optometry accepts only Visa, Mastercard, cash, CareCredit as payment method; no checks accepted.

Full Payment is due at the time services rendered. All sales are final! Any cancellation incurs a 15% re-stocking fee.

I agree to any of my Insurance Co.'s reimbursement issued to Spectrum Optometry for any service/product rendered/purchased.

I understand that my insurance is a contract between my insurance company and I; that Spectrum Optometry is merely a Carrier. If my insurance company failed to reimburse in a timely manner, I will be responsible for the payment of the charges incurred.

In the event that Collection Agency is involved, I hereby agree to fulfill my obligation to the best of my ability. I further agree to pay all legal collection costs on my account (including, but not limited to 18% annual finance charge, 6.5% monthly, on all accounts with balances over 90 days that are patient responsible, this includes any collection fees incurred.)

I understand & agree that my confidential medical information is to be released upon my insurance's request for the purpose of Health Care Operations, including but not limited to, provider review functions, claims payment and quality assessment. I am acknowledging that I have been offered the opportunity to review the HIPPA Notice of Privacy practices.

By signing below, I agree to all the above terms, including a third-party legal arbitration as the only course of action. I further agree to the Spectrum Optometry's contacting me on the communication means provided above.

SIGNATURE _____ DATE _____ (a minor's signature here not allowed)

Free Rx Sun lenses*

*Do you have a family member or friend that hasn't had an eye examination within the last year? Once your referral completes an eye examination here, you may redeem your free Rx sunglasses voucher. *Inquire our staff on restrictions!*