PATIENT INFORMATION

Patient Name _____DOB_____ Age____ Gender _____ Date _____

Address _____ City, State, Zip_____

Home Phone_____ Work Phone _____Cell Phone_____

Employer_____ SSN _____

Married / Single/ Divorced/ Widowed Spouse or Parent/Guardian Name_____

Spouse SSN(if VSP/VCP): _____

Referred By: _____ Yellow Pages _____ Doctor (Name) _____

_____ Employer _____ Previous Patient (Name) _____

_____ Other _____

Statement of Financial Policy

Our office is doing everything possible to keep the cost of your eyecare down. In order to do this, we ask that payment be made when services are rendered. This includes all materials. *Any payment plan or partial payments will have to be approved by the doctor.*

REGARDING INSURANCE: We wish our patients to know that we are providers only for the insurance programs listed below. **PATIENTS ARE RESPONIBLE FOR ALL COPAYS, DEDUCTIBLES, AND NON-COVERED CHARGES. IN THE EVENT THAT YOUR INSURANCE COMPANY DENIES COVERAGE FOR ANY REASON OR HAS NOT MADE PAYMENT WITHIN 90 DAYS OF THE TIME OF SERVICE, THE PATIENT IS RESPONSIBLE FOR PAYMENT.** For other insurance programs, we will prepare necessary forms to help you obtain benefits, but payment is expected at time of service.

Please indicate below your preferred method of payment:

_____ Cash or Check
_____ Mastercard or Visa
_____ Southland National
_____ Vision Service Plan (VSP)
_____ Vision Care Plan (VCP)
_____ Ameritas
_____ Tri-Care

_____ Medicare
_____ Medicaid
_____ BCBS (PMD)
_____ BCBS (State)
_____ BCBS (Federal)
_____ Allkids
Other:_____

I do hereby agree that all charges and/or materials are due and payable at the time of said service and/or material order. *I have read and understand the above policy*.

_____ _____

Patient or Responsible Party Date Signed

INSURANCE AUTHORIZATION OF PAYMENT & RECORD RELEASE

I request that payment of authorized benefits be made to Dr. John T. Bender, OD or Bender Eyecare on my behalf for any services or item furnished by the physician or the supplier. I authorize any holder of medical information regarding me to release to my insurance company, the Health Care Financing Administration, an its agents any information needed to determine those benefits or the benefits payable for related services. I understand that Bender Eyecare will make every effort to obtain benefits owed me through my insurance company. However, in the event that my insurance company will not cover certain procedures, I am aware that I will be personally responsible for any remaining balance.

Signature _____ Date _____

I have received a copy of Bender Eyecare "Notice of Privacy Practices".

Signature _____ Date _____