



CHEYENNE VISION CLINIC, P.C.
PATIENT INFORMATION

NAME (Last, First, M) _____ Birthdate ____/____/____ Age _____

WHAT IS THE REASON FOR YOUR VISIT TODAY _____

_____ **DO YOU WANT NEW GLASSES** _____

Name of Nearest Relative Not Living With You _____ Telephone _____

If Referred: Another Physician _____ TV _____ Radio _____ Newspaper _____ Other _____

Have there been any changes to the health of you or your family since your last eye exam
(explain) _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (Must be age 18 or older)

Name (Last, First, M) _____

Address _____ Years There _____

City _____ State _____ Zip _____ Telephone (H) _____ (W) _____

Social Security Number _____ Driver Lic. No., _____ Patient SS# _____

Previous Address _____ City _____ State _____ Zip _____

Patient or Parent Employer _____ Years There _____ Telephone _____

Position _____ Employers Address _____

Spouse Name _____ Spouse Employment _____

Payment Method (circle) Cash Check Credit Card

Credit Policy

I understand that all services and materials charges incurred are my responsibility and all co-payments and insurance overages are due at the time of service. A FINANCE CHARGE of 1% will be incurred monthly on all accounts with a balance. I may pay the total balance due at any time without penalty or additional FINANCE CHARGES. I am responsible for the cost of COLLECTION and reasonable attorney fees.

I have read and understand the credit policy listed above.

Signed _____ **Date** _____

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WELCOME TO THE CHEYENNE VISION CLINIC, P.C.
“LIFE HAS NEVER LOOKED BETTER”
FROM EYE GLASSES AND CONTACT LENSES TO MEDICINE AND EYE INJURIES
WE HAVE ANSWERS TO YOUR VISION NEEDS FOR A LIFETIME

YOUR INSURANCE INFORMATION

Name of Insurance Company _____ **Telephone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Name of Insured _____ **Relationship to Insured** _____

Insured Telephone Number _____ **Insured Group Name** _____

Insured Social Security # _____ **Patient SS#** _____ **Group/Policy Number** _____

Secondary Insurance Company _____ **Telephone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Insured Telephone Number _____ **Insured Group Name** _____

Insured Social Security # _____ **Patient SS#** _____ **Group/Policy Number** _____

CHEYENE VISION CLINIC, P.C. INSURANCE POLICY

As a courtesy to you , our clinic will submit claims to your insurance company for you. However, we cannot accept liability for collecting your claim because the policy is a contract between you and your insurance company.

I agree to furnish the appropriate insurance information to the Cheyenne Vision Clinic, P.C. so that they may submit charges to my insurance company. If I do not have this information I understand that I am responsible for the charges in full on the date of service.

I hereby authorize benefits, which I am entitled, to be paid to the Cheyenne Vision Clinic, P.C. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges not paid by my insurance. Any portion of the claim not covered within 30 days will be my responsibility. I understand that after 30days the Cheyenne Vision Clinic, P.C. will continue to help collect my benefits from my insurance company.

ALL CO-PAYMENTS AND OVERAGES ARE DUE AT THE TIME OF SERVICE

I have read and understand the above insurance policy. I also hereby authorize Cheyenne Vision Clinic, P.C. to release any information acquired in the course of my care for insurance purposes.

Signed _____ **Date** _____

THANK YOU FOR ALLOWING US TO DELIVER YOUR EYECARE
FROM EYE GLASSES AND CONTACT LENSES TO MEDICINE AND EYE INJURIES
WE HAVE ANSWERS TO YOUR VISION NEEDS FOR A LIFETIME