



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

Payment Agreement

I, the undersigned patient/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand by Cheyenne Vision Clinic "clinic". I further agree that in the event of non-payment to the clinic of any amounts due under this agreement, I will pay interest and late fees thereon at the rate of 1.75% per month, and \$20.00 late payment fees for each billing cycle (monthly), and all of the Clinic's legal fees and court costs that may be incurred. I agree that in the event that this agreement is assigned to Rocky Mountain Recovery (a collection agency) for collection, I promise to pay a collection fee of 35% of the unpaid balance which is in addition to the unpaid balance due under this agreement.

Signature of Patient/Guardian _____ **Date** _____

WELCOME TO THE CHEYENNE VISION CLINIC, P.C.

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**