EYECARE CENTER OF ST. JAMES
Welcome to our office!

This information becomes part of your permanent record and as such is held in complete confidence unless you authorize its release in writing.

*Name*____ *M or F*

*Address*______________________________ *City*_____________ *State*_____ *Zip*_____

*Phone: Home*_____________________ *Cell:* _______________________

Work Place: ______________________ *Work Phone:*________________

Date of Birth: ___/___/___ *Age*____

Spouse: _____________________ *Phone #*_______________________

Parent(s) If a minor _________________________ *DOB:*__________ *Phone #*________________

E-Mail Address: ______________________________________

****To whom can we thank for referring you to our office?* ___________________________

Insurance ______________________ *Policy Holder:*____________________________

I understand that this office will act as my agent in obtaining payment from my Insurance company. However, I further understand that I am ultimately responsible for my bill, including services not covered by Medicare or my Supplement.
I understand that in the course of providing services to me, this office creates, stores, and receives information that identifies me.
I authorize this office to use and disclose this identifying information as necessary for my treatment, payment healthcare operations.
I authorize payment from my Insurance Company to be made directly to this office.
I acknowledge that I have received a copy or have seen it posted for me to read of this office's Notice of Privacy Practice.
I permit a copy of this authorization to be used in place of the original.

Payment Policy

Payment is expected at the time services are provided. Half the balance is expected when your glasses or contact lens order is placed, with the rest due at delivery. We accept the following forms of payment: Cash, Check, Debt or Credit Card. This also applies if you are waiting for payment from insurance or a flex account. If there are any questions concerning your bill, please do not hesitate to ask. Your signature below indicates that you have read, understand and agree to all of the above policies. Thank you!

Name (please print) ____

Signature ____ Date ___________