

FINANCIAL INFORMATION

Name of Patient _____ Birth Date _____ Gender M F

RESPONSIBLE PARTY

Name _____ SSN _____ Birth Date _____

Relationship to Patient: Self Father Mother Other _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile _____ Work _____

EMERGENCY CONTACT

Relative or Contact Person not living with you _____ Phone _____

VISION AND MEDICAL INSURANCE

Please circle any of the insurance carrier(s) through whom you have **vision** or **health insurance**:

VSP	EyeMed	Davis Vision	Spectera
Aetna	Altius	Blue Cross/Blue Sheild	Cigna
CCN	DMBA	Educator's Mutual	First Health
Humana	IHC	Medicaid	Medicare
Molina	PEHP	Tricare	United Health Care
Other(s): _____			

Prior to your appointment, you may be asked to provide an ID number for online verification of benefits. If you have an insurance card, please present it to the staff so we may take a copy.

I certify that the above information is correct, and I consent to examination and treatment for myself and/or any minors for whom I am responsible. I authorize Progressive Eye Care, LLC to furnish to my insurance carrier(s) all information and records necessary to process claims for payment. I authorize insurance benefits to be paid directly to Progressive Eye Care, LLC or Dr. Jeff Broadhead, OD.

By signing below, I agree that:

- ✓ **Co-pays are paid at the time of service (or an additional \$25 fee will be added to my account).**
- ✓ **Eyeglass orders require at least a 50% deposit.**
- ✓ **If eyeglass orders are cancelled or a refund is requested after glasses have been made, a restocking fee of 25% of the purchase price will be charged.**
- ✓ **Payment for services rendered is DUE IN FULL within 30 days, regardless of whether insurance is responsible for all or part of the balance.**
- ✓ **After 90 days, unpaid accounts will be sent to a collections firm, and the patient or responsible party agrees to pay collections fees of up to 50% of any amount past due, plus any attorney fees, and costs of suit.**
- ✓ **Payment Plans are available through Care Credit (on approved credit).**

Signature of Patient or Responsible Party _____ Date _____