G.E.C.

Gillette Optometric Clinic PC

Vision Source

WELCOME

Patient Information

Patient's Legal Name_____ Social Security #_____ Birth Date____/____/____

☐ Male ☐ Female Ethnicity_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Domestic Partner

Mailing Address_____ City_____ State_____ Zip_____

Employer_____ Occupation_____

If Student - School Name_____ Grade _____

Spouse_____ Birth Date____/____/____ Cell #_____

Contact Information

Home Phone_____ Cell_____

Preferred contact # ☐ Home ☐ Cell Text Messages ☐ Yes ☐ No

Email_____ Best time to contact you_____

Emergency Contact Name_____ Phone #_____ Relationship_____

Who would you like to have access to your medical information?_____

Guardian Information

Father's Name_____ Social Security #_____ Birth Date____/____/____

Mailing Address_____ City_____ State_____ Zip_____

Email Address_____ Employer_____

Mother's Name_____ Social Security #_____ Birth Date____/____/____

Mailing Address_____ City_____ State_____ Zip_____

Email Address_____ Employer_____

Insurance

Vision Insurance Name_____ ID#_____ Group #_____

Member Name_____ Social Security #_____ Birth Date____/____/____

Member Phone #_____ Member Employer_____ Relationship to Patient_____

Medical Insurance Name_____ ID#_____ Group #_____

Member Name_____ Social Security #_____ Birth Date____/____/____

Member Phone #_____ Member Employer_____ Relationship to Patient_____

Authorization For Benefits and Medical Release and Acknowledgement of Privacy Practice

I authorize insurance payments directly to Gillette Optometric Clinic PC. I further authorize the release of any information necessary to process claims on my behalf. I understand and agree that I am financially responsible for any charges incurred by me or any family member regardless of insurance. I further understand that any legal fees or interest charges from collection of these fees shall be my responsibility. I acknowledge that I have received a copy of Gillette Optometric Clinic PC Notice of Privacy Practice related to HIPAA.

Signature of Responsible Party_____ ***Date***_____

Gillette Optometric Clinic, PC
Financial Protocol

- Payment is expected at time of service.
- Divorced parents: We are not a party to the divorce agreement. Therefore, the responsible party is the parent who accompanies the child to our office.
- Half down on eyewear orders and balance at pick up of product.
- We file claims with most insurance companies provided we have current insurance information.
- Copays and deductibles are due at time of service.
- Balances over 30 days are assessed a finance charge of 18% APR (1.5% per month).
- Following 90 days of nonpayment, past due accounts will be turned over to a collection agency.
- Returned checks are subject to a $25.00 NSF fee and applicable postage.
- Patients are responsible for any emergency fees incurred, even if the insurance does not cover.
- Previous collections or NSF check: Any future appointments require the balance be PIF at the time of the exam and/or materials' purchase with cash or credit card.

I, _____, hereby acknowledge that I have read, understand, and agree to all of the terms and conditions listed above.

Signature: _____

Date: _____