MID-COLUMBIA EYECARE CENTER INC

Welcome to Our Office

Welcome to Mid-Columbia Eyecare Center Inc. Thank you for choosing us for your eyecare needs.

We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

First Name ______ MI ______ Last Name ______ Preferred Name ______

Street Address ______ City ______ State Zip ______

Social Security Number ______ Date of Birth ______ Home Phone-Include Area Code ______ Day Phone ______

Email Address ______ Guardian ______ Person Responsible for Account ______

Emergency Contact ______ Emergency Phone ______

Communication Preference

☐ Email ☐ Text ☐ Phone ☐ Letter ☐ Secure Messaging ☐ Declined

Please check the appropriate box and sign below to give us permission to contact you.

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company ______ City ______ State Zip ______

M ☐ F ☐ Insured's First Name ______ MI ______ Insured's Last Name ______

Insured's Identification Number Group Number ______ Insured's Date of Birth ______

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

____

Name and Address of Secondary Insurance Company City State Zip

M ☐ F ☐ ______________________________ _____ ______________________________

Insured's First Name MI Insured's Last Name

_________________________ __________ ________ **Patient Relationship to Insured**

Insured's Identification Number Group # DOB Self ☐ Spouse ☐ Child ☐ Other ☐

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered, unless a financial contract has been made in advance. We would rather control billing costs than be forced to raise our fees. An estimate on the portion that your insurance will not pay is also collected at the time of service. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to **MID COLUMBIA EYECARE CENTER INC PS**.

I understand that all services will be billed to my primary insurance, and the secondary insurance, if we have the correct information. I understand that any unpaid charges are my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

______________________________________ __________________________

Signature Date