Winchester Eye Specialists Patient Face Sheet

Please complete all the fields below.

First Name   Middle Initial   Last Name   Date of Birth   Sex

SS Number: ______________________   Marital Status: S   M   D   W

Home Phone   Cell Phone   Emergency Phone Contact Name and #

Street Address   City   State and Zip Code

Financially Responsible Party- Name and Address IF different from above

Primary Insurance

Group #

Insured Name   Policy #

Insured DoB   Insured relationship to Patient

I request that payment of authorized Medicare and/or above noted insurance be made to Drs. Reuling, Keenan, Garringer, Stine and Medical Optical Lab, for any services furnished to me. I understand some services provided are not covered by my insurance carrier and I agree to pay for such services as well as any copay amounts designated by my insurance. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable related to services.

I understand that an EYE EXAM includes a medical examination of my eyes and often a refraction, which may lead to a glasses prescription. I understand that there is now a $30.00 refraction fee that will not be billable to my insurance companies and I will be responsible for payment at the time of service. The refraction does not include contact lens fitting, corneal measurements or contact lens specifications. The contact lens portion of your exam will have a $50.00 - $200.00 charge which will be a fee that is separate from any eye exam fees/copayments. In all cases, professional fees are the responsibility of the patient and/or the stated financially responsible party.

Patient or financially responsible parties further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and Attorney fees, court expenses, service and filing fees.

A missed appointment not canceled with 24 hour notice may incur a $25.00 fee. This is billed to the patient's account and is not covered by insurance.

X ____

Patient and/or Financially Responsible Party Signature   Date

For Office Use Only: Acct # ________   Office: CAM   MOB   WS   Date____________