Date:_____ **Patient Information** Account #_____

Patient's Name:_____ Title _____ Nickname_____
Address:_____City:_____State:_____ Zip:_____

Home Phone: (____)_____Work Phone: (_____)_____X____ Cell: (____)_____

Email: _____ DOB:_____ Age:_____

Gender:____ Marital Status:_____ Occupation:_____ Grade if Student:_____

Patient's School or Employer _____ City: _____

Parent's/Guardian's Names: _____

Account Responsible's Name: _____ Relation to Patient: _____

Address: □ (check if same as above) _____SSN#:_____

Work Address:_____ Work Phone:_____

Primary Insurance Company:_____ Ins. Phone:_____

Name of Insured: _____ SSN#_____ Relationship to Insured: Self -Child -Spouse

Insurance ID#_____ Group #: _____ Sponsor's DOB: _____

Patient's Primary Physician:_____Phone: _____

Patient's Primary Eye Care Provider: _____Phone: _____

Referred by:_____ City:_____ Phone:_____

□ **Check Here if You Authorize the Sharing of Information with the Above Providers**

Comments_____

The Center for Vision Therapy, PLC does not participate on insurance panels nor accept insurance assignment. You are responsible for any referrals or authorizations. Any additional information, reports or forms provided beyond the initial one will incur additional costs to the patient. Services provided may not be covered services and you consent and authorize all such services & treatments. We accept no insurance payments but you might be eligible for reimbursement. Check with your insurance company if you feel your policy may cover services.

□**Check here to request a courtesy claim form or superbill for submission to your insurance company & authorize the release of information.**

You are responsible for payment in full of all charges at the time of service.

The fee for any returned checks is $45. Missed appointments without 24 hours prior cancellation notice are charged at the usual rate. Any outstanding debts incur a 3% finance fee per month and an additional 50% surcharge if collection actions are initiated plus costs.

You have received a copy of our Privacy Policy and have read, understood and agree to the above.

Patient/Parent (If Minor) **Signature:**_____ Date:_____