You will need Acrobat 9.0 or later for this form to work probably. (FREE upgrade from www.adobe.com)
After completing form you may: 1) print form and bring it to us, 2) fax form to us.

TRUSSVILLE VISION CARE

PERSONAL INFORMATION

DATE_____ DATE OF BIRTH_____/_____/_____ AGE_____ SS#_____ _____ _____

NAME ☐ DR ☐ MR. ☐ MRS. ☐ MS. _____
FIRST MIDDLE LAST

HOME ADDRESS _____ HOME PHONE# _____

CITY _____ STATE_____ ZIP _____ WORK PHONE# _____ CELL PHONE# _____

OCCUPATION _____ EMPLOYER/SCHOOL _____

GUARDIAN (IF UNDER 18) _____ RELATIONSHIP _____

ADDRESS (IF DIFFERENT) _____ CITY _____ STATE_____ ZIP _____

E-MAIL _____

HOW DID YOU FIND OUT ABOUT TRUSSVILLE VISION CARE? ☐ YELLOW PAGES ☐ RADIO ☐ INSURANCE ☐ WEBSITE ☐ FAMILY ☐ FRIEND

WHOM SHOULD WE THANK FOR REFERRAL? _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ MEMBER# _____

PERSON INSURED _____ DATE OF BIRTH_____/_____/_____ GROUP# _____

RELATIONSHIP TO PATIENT _____ SECONDARY INSURANCE _____

MEMBER ID# _____ GROUP# _____

SIGNATURE ON FILE

I hereby authorize payment of Medicare and/or Medigap, or other health insurance benefits to Samuel D. Pierce, O.D., P.C. for professional services rendered. I authorize the release of any necessary medical information, including copies of medical records, for determination of payment of benefits. I understand Dr. Samuel D. Pierce accepts assignment for Medicare, Blue Cross, and certain other HMOs and PPOs with which he is affiliated, and that I am responsible for any deductions, co-pays and/or fees for non-covered services such as office visits, without required referral, refraction fees, non-medically related office visits, deluxe frames not covered by any insurance/vision plan (when applicable) and contact lens fitting fees,

_____ DATE _____
RESPONSIBLE PARTY'S SIGNATURE

FINANCIAL POLICY

If you have insurance with which we are unfamiliar, or that we know from experience will not pay benefits directly to us, the undersigned will be responsible for fees for services rendered, and we will gladly file your insurance for reimbursement to you. However, it is the undersigned's responsibility to handle any and all problems that arise with your insurance company. Again, we are happy to re-file any claims per the undersigned's request after the insurance company has been contacted to verify that re-filing is necessary.

Trussville Vision Care cannot guarantee anything about the undersigned's insurance as the contract is between the undersigned and their Insurance company, not with this office. We will assist in any way possible, but it is the responsibility of the undersigned to know their insurance. The undersigned is responsible for obtaining referrals when necessary.

If a balance remains on the account after 90 (ninety) days, a 1.5 % late fee will be added monthly to the unpaid balance. There is a $30 returned check fee.

A fifty percent deposit is required on all eyewear. Full payment is due on all contacts when an order is placed.

I HAVE READ AND UNDERSTAND THE ABOVE STATED FINANCIAL POLICY AND AGREE TO ALL CONDITIONS. I ALSO AGREE THAT IN THE UNUSUAL EVENT THAT MY ACCOUNT BECOMES DELINQUENT, I WILL PAY ANY COLLECTION FEES REQUIRED TO SETTLE MY ACCOUNT.

_____ DATE _____
RESPONSIBLE PARTY'S SIGNATURE