Family Eye Care

Dr. Helen J. Zervas, Optometrist

860-584-5528

PATIENT & INSURANCE INFORMATION

NAME: _____

DATE OF BIRTH: _____/_____/_____ **AGE** _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY _____ **STATE** _____ **ZIP** _____

HOME PHONE _____ **WORK PHONE** _____

EMERGENCY PHONE _____

OCCUPATION _____

SPOUSE'S NAME _____

EMERGENCY PHONE _____

REFERRED BY _____

PRIMARY INSURANCE PLAN: _____

GROUP# _____ **POLICY #** _____

SECONDARY INSURANCE PLAN: _____

GROUP # _____ **POLICY #** _____

PAYMENT POLICY

PROFESSIONAL FEES ARE DUE AT THE TIME THE SERVICES ARE RENDERED. A DEPOSIT OF HALF OF THE TOTAL COST OF PRESCRIPTION EYEGLASSES OR CONTACT LENSES IS REQUIRED IN ADDITION TO THE EXAMINATION FEES. THE BALANCE OF YOUR EYEGLASSES AND / OR CONTACT LENSES IS DUE WHEN THEY ARE DISPENSED. THERE WILL BE A $20.00 RETURN CHECK FEE. PATIENTS WILL BE BILLED BY THIS OFFICE ON A MONTHLY BASIS EVEN IF EYEGLASSES OR CONTACT LENSES HAVE NOT BEEN DISPENSED OR IF AN INSURANCE CLAIM HAS BEEN FILED.

LIFETIME AUTHORIZATION / SIGNATURE ON FILE

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS (INCLUDING MEDICARE) FOR ANY SERVICES FURNISHED TO ME, BE MADE ON MY BEHALF TO DR. HELEN J. ZERVAS. I AUTHORIZE 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 FOR RELATED SERVICES.

METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ MASTERCARD ☐ VISA

SIGNATURE _____ **DATE:** _____/_____/_____

CLEAR SAVE EMAIL PRINT