Dr. Carroll, Dr. Lahiff, Dr. Wells

CHEYENNE VISION CLINIC

PATIENT INFORMATION

To fill out the following form paper-less, is simple. It can only be opened in Microsoft Word, if there are any error/ warning alerts located under your tool bar you might have to enable editing. When you get the alerts settled you should be able to click in any shaded-area to add your information. The boxes shaded in grey simply require a click to display the possible answers, and any little check boxes just need to be clicked to mark the box.

NAME (Last, First, M.) _____, _____ ____ Birthdate ___/___/_____ Age ___

WHAT IS THE REASON FOR YOUR VISIT TODAY _____

DO YOU WANT NEW GLASSES? ____

Name of Nearest Relative Not Living With You _____ Telephone (____)_____-_____

How were you referred: Another Physician ☐ TV☐ Radio☐ Newspaper☐ Other _____

Have there been any changes to the health of you or your family since your last eye exam (explain)

_____

Language _____ Race _____ Mother's Maiden Name _____

Birth State _____ Birth Country _____ E Mail _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT
(Must be age 18 or older)

Name (Last, First, M) _____, _____ ____

Address _____ City _____ State __ Zip _____ Years There? ____

Telephone: Home (____)_____-_____ Cell (____)_____-_____

Social Security Number: _____ Driver Lic. No. _____ Patient SS# _____

Previous Address _____ City _____ State _____ Zip _____

Employer _____ Years There __ Telephone (___)____-_____ Position _____

Employers Address _____ City _____ State __ Zip _____

Spouse Name _____ Spouse Employment _____

Payment Method (check one of the following) ☐Cash ☐Check ☐Credit Card

I, the undersigned patient/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand by Cheyenne Vision Clinic "clinic". I further agree that in the event of non-payment to the clinic of any amounts due under this agreement, I will pay interest and late fees thereon at the rate of 1.75% per month, and $20.00 late payment fees for each billing cycle (monthly), and all of the Clinic's legal fees and court costs that may be incurred. I agree that in the event that this agreement is assigned to Rocky Mountain Recovery (a collection agency) for collection, I promise to pay a collection fee of 35% of the unpaid balance which is in addition to the unpaid balance due under this agreement.

Signed _____ **Date**_____

Please know that by filling in the form above you are agreeing that you have read the above information and for all intents and purposes, in the court of law especially, you have signed this agreement.

Dr. Carroll, Dr. Lahiff, Dr. Wells

CHEYENNE VISION CLINIC

Insurance Policy and Form

Your Insurance Information

Name of Insurance Company_____

Name of Insured _____

Patient's relationship to the Insured _____ Insured Telephone Number _____

Insured's Social Security Number _____ Group/ Policy Number _____

Insured's Date of Birth _____

CHEYENNE VISION CLINIC, P.C. INSURANCE POLICY

As a courtesy to you, our clinic will submit claims to your insurance company for you. However, we cannot accept liability for collecting your claim because the policy is a contract between you and your insurance company.

I agree to furnish the appropriate insurance information to the Cheyenne Vision Clinic, P.C. so that they may submit charges to my insurance company. If I do not have this information I understand that I am responsible for the charges in full on the date of service.

I hereby authorize benefits, which I am entitled, to be paid to the Cheyenne Vision Clinic, P.C. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges not paid by my insurance. Any portion of the claim not covered within 30 days will be my responsibility. I understand that after 30 days Cheyenne Vision Clinic, P.C. will continue to help collect my benefits from my insurance company.

ALL COPAYMENTS AND OVERAGES ARE DUE AT THE TIME OF SERVICE

I have read and understand the above insurance policy. I hereby authorize Cheyenne Vision Clinic, P.C. to release any information acquired in the course of my care for insurance purposes.

Signed: _____ **Date:** _____

Please know that by filling in the form above you are agreeing that you have read the above information and for all intents and purposes, in the court of law especially, you have signed this agreement.

THANK YOU FOR ALLOWING US TO DELIVER YOUR EYECARE

FROM EYE GLASSES AND CONTACT LENSES TO MEDICINE AND EYE INJURIES

WE HAVE ANSWERS TO YOUR VISION NEEDS FOR A LIFETIME