Welcome to Your Eyes Image

Date_____

Patients Name _____

Street Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Contact Phone_____

Email _____ Occupation _____

Insurance _____ Last 4 of member SSN _____

At **Your Eyes Image**, our goal is to provide you with the best eye health care and a positive experience. In order to establish and maintain a pleasant professional working relationship with you, please take a few moments to review the following information.

Insurance: The ultimate insurance relationship is between our office and you, not our office and your insurance company. If you have vision insurance, we will bill them as a courtesy to you. To do this correctly and promptly, we need the most current and accurate information, including verification of insurance and proper identity.

We will do our best to determine benefits before your appointment time if we have current insurance information. If this is not possible, during your appointment, our staff will contact your insurance company to determine coverage within your plan. **This is not a guarantee of payment benefits by your insurance. Any unpaid balance will be billed to you.**

I understand that in the event my insurance does not pay for the billed services, I am responsible for the payment of services in a prompt manner. Payment is due at the time services are rendered.

_____ _____

Patient/Parent Signature Date