Frankfort Vision Center Patient Registration Form

Welcome to our office! Thank you for choosing Frankfort Vision Center for your eye care services. Please take the time to complete this form accurately and completely. It helps us to do the best job possible for you. This information is held in complete confidence as it is part of your permanent record and it will not be released to anyone unless you authorize its release in writing.

Patient Information

Name(First, Middle, Last)_____Nickname:_____
Address:_____City:_____State:_____Zip:_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Social Security Number:_____Date of Birth:_____ ☐Male ☐Female
Email Address:_____
Employment Status: □ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student ☐ Stay at home Parent ☐ Child
Employer Name:_____Employer Phone:_____
Emergency Contact (Not living with you) Name:_____Phone:_____

Responsible Party Information (□Check if same as above)

Last Name_____First Name:_____Middle Name:_____
Address:_____City:_____State:_____Zip:_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Social Security Number:_____Date of Birth:_____ ☐Male ☐Female
Email Address:_____

Insurance Information

We require all insurance information prior to services being provided. Due to the diverse nature of many eye conditions, disorders, procedures and treatments many of the services we provide are covered under your MAJOR MEDICAL INSURANCE rather than routine vision coverage. Please provide us with the following information even if you believe that you are seeing us for a non-medical reason.

MEDICAL

Primary Insurance Co_____Policy ID #_____
Policy Holder Name_____Policy Holder Date of Birth_____ Policy Holder Sex □M □F
Policy Holder SSN_____Policy Holder Employer_____

Secondary Insurance Co_____Policy ID #_____
Policy Holder Name_____Policy Holder Date of Birth_____ Policy Holder Sex □M □F
Policy Holder SSN_____Policy Holder Employer_____

VISION

Primary Insurance Co_____Policy ID #_____
Policy Holder Name_____Policy Holder Date of Birth_____ Policy Holder Sex □M □F
Policy Holder SSN_____Policy Holder Employer_____
Do you have a secondary vision insurance? □Yes □No

Frankfort Vision Center Policies (*Please read and sign below*)

Contact Lenses: If you are a contact lens wearer, there will be an additional charge for your exam for a contact lens evaluation. This fee includes review of lens hygiene, lens selection, evaluation of the lens on the eye, any training required, lens change if required and all contact lens related follow up visits for 60 days. The level of fee assessed is based upon the type of contact lenses you wear and the complexity of your prescription.

Financials: Full payment is due at the time of service. Cash, check and credit cards are accepted. All exchanges of materials must be done within 30 days of purchase. There are no refunds for professional services. There is a $25 fee for all returned checks. A finance charge of 18% APY will be assessed to any account past 90 days and a $20 collections fee will be charged if your account becomes delinquent. Any refund less than $10 will be credited to your account.

Insurance: All co-pays and deductibles are due at the time of service. Please be aware that some, and perhaps all, of the services provided may not be covered. The balance is the responsibility of the patient whether the insurance pays or not.

I authorize the release of any medical information to process this and any further claims. I authorize assignment of all medical benefits to Frankfort Vision Center.

Signature:_____Date:_____