HERITAGE EYE CARE

81 River St Montpelier, VT 05602

PATIENT:

_____
First Name Initial Last Preferred Name

Mailing Address_____City _____State _____ Zip _____

Sex: ❑ M ❑ F Date of Birth_____**Communication Preference**: Postal ❑ Telephone ❑ Email ❑ _____

Employed by _____ Occupation_____

Home Phone_____Work Phone _____ Cell Phone _____

❑ Spouse ❑ Partner ❑ Civil Union _____ Spouse/Partner Work Phone _____

RESPONSIBLE PARTY:

_____ Relationship to Patient_____

Address (if different) _____ Home Phone (if different)_____

Employed by _____ Date of Birth _____

How did your hear of Heritage Eye Care?_____

Preferred Language: ❑English ❑Spanish ❑French

Race: ❑American Indian or Alaskan Native ❑Asian ❑Black or African American
❑Hispanic/Latino ❑Native Hawaiian/Pacific Island ❑White

Ethnicity: ❑Hispanic/Latino ❑Native Hawaiian/Pacific Island ❑ Not Hispanic or Latino

INSURANCE INFORMATION – Fill out if Cards are not available to COPY

Primary Insurance: Guarantor:

ID # _____

Group # _____

Secondary Insurance: Guarantor:

ID # _____

Group # _____

Assignment and Release

❑ "I request that payment of authorized Medicare benefits be made to me or on my behalf to Todd A Page, O.D.of Heritage Optical for any services furnished to me by that provider. 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."

❑ "I request that payment of authorized Medigap benefits be made to me or on my behalf to Todd A Page, O.D. of Heritage Optical for any service furnished me by that provider. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services

❑ "I request that a claim for vision or medical benefits be made on my behalf for any service furnished by Heritage Optical or Todd A Page, O.D... I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services." Payment is due to Heritage Optical at the time or service. If insurance payment is made to Heritage Optical on my behalf, then Heritage Optical will reimburse me

The above information is accurate and complete to the best of my knowledge and is confidential and only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my optometrist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand I may revoke this consent in writing.

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child/dependent. I accept full financial responsibility for all charges not covered by insurance. I understand all accounts over 30 days old will be charged 18% per annum interest.

Signature _____Date_____