AS A COURTESY, WE WILL FILE MOST INSURANCE CLAIMS WHEN YOU **COMPLETE** THE SECTION BELOW AND PROVIDE THE FOLLOWING:

Patients Name _____ Patient DOB _____

How do you prefer to get notified for your next appointment? (Please circle your choices)

Home Phone **Cell Phone** **Text Message** **Postcard** **Email**

Patient Employment/School Status **PLEASE CIRCLE ONE** Patient Status

Employed Full-Time | Employed Part- Time | Not Employed | Single | Married | Widowed

Retired | Full- Time Student | Part- Time Student | Divorced | Legally Separated

Email Address _____

Primary Medical Insurance _____ Policy # _____

Policy Holder SS# _____ Relationship to Patient _____

Policy Holder _____ Policy Holder DOB _____

Vision Plan _____ Policy Holder SS# _____

Policy Holder _____ Relationship to Patient _____

Policy Holder DOB _____ Policy # _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed Sitterle Vision Source's Notice of Privacy Practices.
I (please circle one) **DO** **DO NOT** wish to receive a copy of this

Printed Patient Name:_____
If patient is a minor, name of parent/guardian:_____

Signature:_____ Date:_____

To our patients:

It has become necessary to put our office policy in writing. Payment is due when services are rendered. This keeps office expenses down; and in turn keeps our fees down. We accept cash, checks, MasterCard, Visa, Discover and American Express.

Regarding Insurance:

If your care is to be paid through an insurance program, you must have the appropriate information and forms with you. These forms should be fully completed and signed in all the proper places. Due to the high number of insurance and third party plans in use, it is impossible for us to always know what your program covers. Individual programs change from year to year and form patient to patient. You, the subscriber, should have an information booklet explaining the extent of your coverage. We urge you to refer to it.

Our insurance specialist will do her best to obtain all of the appropriate information, prior to your arrival to our office. But the ultimate responsibility for determining whether or not you are eligible for benefits rests with you. In some instances, even though we are able to verify your eligibility for services, this is not a guarantee of payment.

If we are not familiar with your insurance carrier, you may be asked to pay for your services, in full, as they are rendered and you will be reimburse directly by your insurance carrier. If this is the case, we will be happy to process the forms for you at no additional charge.
Thank you

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any services rendered and materials purchased. If my insurance denies payment or there is an unpaid balance, this amount becomes my responsibility and the balance is due within 30 days.

I have read the information on this page and do hereby agree to comply with these terms.

Signed _____ Date _____

If signed for a minor, relationship to minor _____

Thank you for your understanding and cooperation.