River Region Vision Source
Patient Information

Date_____

Name:_____ Date of Birth:_____
SSN:_____

Address:_____City:_____
State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

E-Mail:_____
Occupation:_____

Medical Doctor/PCP:_____
Pharmacy:_____

Vision Insurance:_____ Policy Holders SSN:_____

Medical Insurance:_____ Policy Holders SSN:_____

HIPPA Release: Please list persons that you will allow River Region Vision Source to release your medical and financial information

_____
_____
_____
_____
_____
_____
_____

****Please present you insurance cards and driver's license to the receptionist****

River Region Vision Source
Financial Agreement

I understand by signing this document that I am accepting full financial responsibility for my account.
I understand that fees are due at the time of service and that fees not covered by insurance are my responsibility. I understand that I am solely responsible for any collection costs and attorney fees that may be incurred due to failure to pay. I understand that if my insurance does not respond within 60 days, I am fully responsible for my account. I authorize use of this form for all my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original.

River Region Vision Source accepts all major credit cards as well as cash or check. *Care Credit is also accepted and allows for up to 2 years interest free financing*

No prescriptions for spectacles or contact lenses will be released on unpaid accounts.
Spectacle Rx's, Contact Lens Rx's, or Contact Lens replacements will not be given after one year from exam date.

Patient/Guardian Signaure:_____

Date:_____

*Subject to credit approval from Care Credit.