Spectrum Optometry

Acct #_________

Last Name _________________________ First Name______________________ Nickname________________ M / F

Birth Date (mm/dd/yyyy) ________-________-___________ Social Security # ________________________________

Occupation ____ Employer / If student, School: __________________

Address ___________________________________ Unit # ______ City __________________ State___ Zip ___________

Home# ( ) _______ - ___________ Work# ( ) _______ - __________ Cell# ( ) _______ - ___________

E-mail ______________________________________ Line ____________________ WeChat _________________________

Race: ❑African American ❑ Alaskan Native/American Indian ❑ Asian ❑Pacific Islander ❑White ❑Other

Ethnicity: ❑ Hispanic/Latino ❑Not Hispanic/Latino ❑Unknown ❑ Language Preference __________________

Vision Insurance Co. ____________________ Relationship to Primary Insured: ❑Self ❑Spouse ❑Child ❑Other

Primary Insured's ID ___________________ Last ________________ First ______________ Birth Date___ -___-_____

Medical Insurance Co. __________________ Relationship to Primary Insured: ❑Self ❑Spouse ❑Child ❑Other

Primary Insured's ID ___________________ Last ________________ First ______________ Birth Date___ -___-_____

Spouse or Legal Guardian

Last ____________________________ First ___________________________ Relationship ______________________ M / F

Address ______________________________ City ___________ State ____ Zip ______ Phone# ( ) ______ -_________

Birth Date (M/D/Y) _________-_________-_____________ Social Security # ____________________________________

Emergency Contact ❑Same as above

Last ________________________ First _________________ Relationship _____________Birth Date ___-___-____ M / F

Address ______________________________ City ___________State ____ Zip ______ Phone# ( ) ______ -_________

Referred by: ❑Insurance ❑Walk-in ❑Friend: ________________ ❑Facebook ❑Brochure ❑Online Media:_________

Office Policy & Disclosure

My confidential medical information is to be released upon my insurance's request for the purpose of Health Care Operations, including but not limited to, provider review functions, claims payment and quality assessment. I acknowledge that I have been offered the opportunity to review the HIPAA Notice of Privacy Practices.

As a courtesy, Spectrum Optometry verifies insurance benefits and coverage on my behalf. I understand that this verification is only an estimation of insurance benefits at the time of verification and in no way a promise on behalf of the insurance company to pay for any services rendered. Therefore I am liable for all charges not covered by insurance as well as deductibles not yet met.

Full Payment is due at the start of all customized glasses, contact lens orders. **All sales are final!**

I hereby have been informed on our 1-year Manufacture Defective Warranty on all current-model eyewear. In the event of defective exchange, there is a $30 handling fee. Moreover, a $30 shipping fee applies to all special-order frames purchased.

In the event of a credit card dispute, I herby agree to be responsible for any incurred charges issued by the credit card company. In the event that a Collection Agency is involved, I hereby agree to fulfill my obligation to the best of my ability. I further agree to pay all legal collection efforts on my 90-day past due debt (including, but not limited to the 10% annually)

I am hereby informed of a **$35** fee for any **requested documents;** excluding prescriptions and DMV forms. Such fees are not limited to complete medical records, summary of your medical records, work/school/camp/sports/insurance physical forms, work/school time off notes, life/health/work disability forms, and any certificates of current medical status. We shall expedite your requested form within 5 business days upon receiving your written request and $35 payment. Orthokeratology lens design file incurs additional $85.

By signing below, I agree to office policy and disclosure, including a third-party legal arbitration as the only course of action from this Date and forward until further notice. I authorize Spectrum Optometry to provide services to me. In addition, I authorize Spectrum Optometry to contact me via information I provided above.

SIGNATURE _________________________________ DATE______________________________

Free Rx Sun lenses*

Dear Patient, do you have a family member/friend who hasn't had an eye examination within the past year? Once your referred person completes an eye examination here, you may redeem your free Rx sunglasses voucher. **Restrictions Apply!*