ALAMEDA VISION CENTER
FINANCIAL POLICY

RESPONSIBLE PARTY INFORMATION

Patient's Name______________________________________Birthdate_____________________ Sex M F

Parent or Guardian____SS#___________________________

Address_____________________________________City__________________State________Zip_______

Home telephone #_____________________ Cell # ______________________Work # _________________

Employer ___________________________________Occupation___________________________________

Emergency Contact Name_________________________________Phone#___________________________

Primary Care Physician__________________________________Pharmacy_________________________

PRIMARY INSURANCE COMPANY____

Name of policy holder________________________Birthdate______________ Phone#_______________

Address_____________________________________City__________________State________Zip_______

Policy #___________________________Group #__________________________SS#___________________

SECONDARY INSURANCE COMPANY____

Name of policy holder________________________Birthdate______________ Phone#_______________

Address_____________________________________City__________________State________Zip_______

Policy #___________________________Group #__________________________SS#___________________

PAYMENT POLICY

Payment is due at time of service. A 50% deposit is required **BEFORE** materials are ordered. The balance is due in full at time of delivery. Third party payment (insurance) will be filed on your behalf; however, payment must be received before dispensing. Any insurance benefit in excess of the account balance will be immediately refunded to the patient after we receive payment from the insurance company.

A finance charge of 1.5% per month (18% annual) of the unpaid balance will be added monthly. Should collections become necessary, the responsible party agrees to pay an additional 30% collection fee and all legal fees of collection with or without suit, including attorney fees and court costs.
I understand the signature below will acknowledge the financial policy as written and agreement to those terms. I t will also authorize release of information and assign benefits.

Signed__________________________________**Date**_____________**Relationship to patient**______________