PATIENT IDENTIFICATION - Please print			
First Name	Middle	Last	
Age	Date of Birth	Address	Apt. #
City	State	Zip	Social Security
Home Phone	Cell Phone	Work Phone	
Employer's Name	Address		
Alternate Contact Person	Phone		
Referred By	Email Address		
GUARANTOR OR FINANCIAL RESPONSIBILITY - If different from above			
First Name	Middle	Last	
Address	City	State	Zip Code
Home Phone	Cell Phone	Work Phone	
Date of Birth	Relationship	Social Security	
INSURANCE-PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST			

I consent to treatment necessary for the care of the above named patient.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I allow fax transmittal of my medical records, if necessary.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. Refractions are not typically covered by insurance or government programs and are the patient's responsibility.

I understand that proof of insurance must be presented at the time of service. I will provide valid insurance information on the day of service. If no insurance information is provided, I understand that payment is due the day of service, and no insurance billing will be provided at a later date.

I authorize and request that insurance payments be made directly to Clear Image Eye Center should they elect to receive such payments.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. In the event, the charges incurred are not paid in full when due and collection action is instituted, whether by a collection agency or attorney, or both, I agree to be responsible for and pay, in addition to the charges for services and treatment received, all costs associated with such collection activity. These costs include, but are not limited to, reasonable collection agency fees, attorney fees, court cost and/or any other expenses incurred in its collection. I also agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone number, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or of an automatic dialing device, as applicable. I have this disclosure and agree that the Physician/Collection Agency may contact me as described about.

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Patient Signature Date