

WELCOME TO LANDSAW EYECARE, YOUR VISION SOURCE!

Appointment Date: _____

Last Name

First Name

Address

City, ST ZIP

DOB

SSN

Cell Phone

Work Phone

Home Phone

Email Address

Male

Female

Employer/School

Occupation/Grade

Insurance Information

Medical Insurance

Subscriber/Member ID

Subscriber Name

Subscriber SSN

DOB

Vision Insurance

Member ID

Subscriber Name

Subscriber SSN

DOB

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Landsaw Eye Care.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you are responsible for providing payment in full to Landsaw Eye Care.

I acknowledge that I received a copy of Landsaw, O.D., P.A.'s Notice of Privacy Practices (Effective 9/23/2013)

I certify that I have and will provide, to the best of my knowledge, Landsaw Eyecare the most up to date information regarding my current health status. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or myself during the period of such eye care, the third party payees and/or health practitioners. If applicable, I authorize and request my insurance company to apply directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I authorize the release of any medical or other information necessary to process claims for my child or myself. I also request payment of government benefits either to myself or to the party who accepts assignment. In addition, I authorize payment of medical benefits to the optometric physician or supplier for services provided to my child or myself. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

We will start your custom spectacle order immediately. For this reason, cancellations on spectacles are not permitted. All glasses are custom crafted for each patient with their unique prescription. Also, all spectacle lenses are custom cut to fit the frame each patient has selected. Therefore, patients may not switch frames after their lenses have been cut. For all of these reasons, cash refunds are not possible. At the doctors' discretion, patients who are not satisfied with the vision in their new glasses will have their prescription adjusted at no cost, within 60 days of the original purchase date. Cash refunds are not available on progressive lenses. However, any patient who fails to adapt to their new progressive lenses will have their prescription remade one time into a lens of their choice at no additional charge. Contact lens purchases are eligible for returns or exchanges 90 days after purchase. All additional policies for products and services please review the **Landsaw Eyecare Policies** form posted.

Patient/Guardian Signature

Date