Welcome to the EYECARE CENTER OF LEESBURG
We are pleased that you have chosen our office to serve your eye health and vision care needs.

Date _____ Birth date _____

Patient's name: Mr. Mrs. Miss Ms. Dr. _____

Address _____

City _____ State _____ Zip _____

Home #_____ Work #_____ Cell # _____

How did you hear about our office? _____

____ Family/Friend ____Insurance ____Yellowpages ____ Our Website ____ Internet ____ other

Your medical insurance company _____ ,policy # _____

Your eye care/vision insurance company _____

Policy holder name and birth date _____

Name & address of person responsible for today's charges _____

May we have your e-mail address? _____

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USING INSURANCE? Please read and initial below

If we do not participate in your eye care plan we will expect payment from you at time of service although we will file a claim on your behalf with your insurer.

If we do participate in your eye care plan we will collect any co-payments or overages at the time of service. We will do our best to verify your insurance benefits and eligibility for services. Sometimes, however, insurance companies do not pay as expected. In this case we will file an appeal on your behalf but will hold you responsible for the cost of your services and/or eyewear. We will abide with the fee schedule/terms of our contract with your insurer.

I have read and I understand and agree to the terms described above (Initial here)

I request that payment of authorized insurance benefits be made either to me or on my behalf to the Eyecare Center. I authorize the Eyecare Center to release to the appropriate insurance carriers any information needed to determine these benefits.

(Sign here) _____ Date _____

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You will probably have eyedrops today to dilate your pupils. Dilating the pupils allows for a more thorough eye health examination. Many eye diseases have no pain or symptoms so a periodic dilated exam is necessary. There is no extra charge for dilation.

The eye drops will make reading difficult and increase light sensitivity for two to four hours. **Driving is not impaired** although sunglasses may be necessary (We provide "disposable" sunglasses if needed).

Please initial ONE choice below

_____ I accept eyedrops/dilation. _____ I'd prefer to defer dilation to a more convenient time.

Thank you! We will begin your exam shortly.

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