# Registration Form

Name ______________________________

Address ______________________________ Today's Date ____________

City/State/Zip Code ______________________________ Home Phone ____________

Guardian (if applicable) ______________________________ Work Phone ____________

Birth Date ______________________________ Cell Phone ____________

Employer ____________________ e-mail address ____________________

Occupation ____________________

How did you learn about our office?

____Another doctor ____ Another patient ____ Advertisement ____Insurance company

____Our office website ____ Insurance website ____ Walking by ____Yellow pages

____One of our staff members (please indicate their name if known)

Person to be contacted in case of emergency (local friend or relative)

Name ______________________________ Relationship ____________________

Phone ____________________ e-mail address ____________________

# Payment and Insurance Information

*Please present your insurance card to our receptionist*

- Payment is due in full for professional services on the day of your examination
- Payment of ½ the total cost of any merchandise (eg; glasses, contact lenses) is required when the order is placed. The balance is due in full upon receipt of the merchandise
- We do not provide payment plans (exception: CareCard)
- Bankcards accepted: MasterCard, Visa, American Express

For those with health insurance:

Vision insurance may be an *optional* coverage under your health plan (similar to dental coverage). Please verify that you are covered for vision.

Insurance eligibility information that is given to us by your insurance company is not a guarantee of coverage. Any balance is the sole responsibility of the billpayer.

Patient's Primary Health Insurance: ______________________________ Group # ________________

Subscriber Name: ______________________________ Subscriber # ________________

Secondary Health Insurance ______________________________ Group # ________________

Subscriber Name: ______________________________ Subscriber # ________________

Name of Vision Insurance Company: ________________________________________

I authorize Broadway Vision Source or the insurance company to release information required to process my claim. I authorize my insurance benefits to be paid directly to Broadway Vision Source. I accept financial responsibility for all account balances. I understand an annual interest rate of 12%, 1% per month, or a minimum rebilling fee of $2.00 per month will be applied to all patient- responsible balances over 90 days.

Signed (Guarantor) ______________________________ Date: ________________