

**Fort Wayne Family Eyecare**  
www.fwfamilyeye.com

**Fort Wayne Family Eyecare North**  
9426 Lima Road  
Fort Wayne, Indiana 46818

**Fort Wayne Family Eyecare South**  
1515 East Paulding Road  
Fort Wayne, Indiana 46816

**PATIENT INFORMATION:**

**DATE:** \_\_\_\_\_

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Home Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_\_

Patient Email Address: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

Spouse Full Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

**WHOM MAY WE THANK FOR REFERRING YOU?** \_\_\_\_\_

**RESPONSIBLE PARTY/INSURANCE BILLING INFORMATION:**

Responsible Party's Full Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Responsible Party's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**NOTICE OF PAYMENT POLICY**

All professional fees, including exam and any additional testing recommended by the doctor, are due and payable the day they are provided. If glasses or contact lenses are included in your fees, total charges are due at the time of order.

If your fees are covered by a vision plan for which we are participating providers, or by Medicare, any applicable deductibles, co-payments and non-covered services and/or materials are due and payable on the date of your examination.

➤ ***I understand that any fees incurred are my responsibility, unless otherwise prohibited by law, regardless of any insurance benefits, and that they are to be paid as stated in the above payment policy. Any collections and/or legal fees are also my responsibility. I authorize Fort Wayne Family Eyecare to release to my insurance carriers any information required to file or resubmit my claim. In addition, I authorize Fort Wayne Family Eyecare to initiate a complaint to the Indiana Insurance Commissioner for any reason on my behalf. I acknowledge that I have been offered a copy of Fort Wayne Family Eyecare's Notice of Privacy Practices.***

Payment will be made by:

- Self/Parent
- Medicare
- Insurance (name) \_\_\_\_\_

\_\_\_\_\_  
Patient/ Parent or Guardian Signature

\_\_\_\_\_  
Date