ALL FAMILY vision care

Welcome to All Family Vision Care! Thank you for taking the time to fill out our patient demographic form.

1597 SW 53rd St. Corvallis, OR 97333 Ph: (541) 757-8844 Fax: (541) 754-9810 www.allfamilyvisioncare.com

Patient Name: _____Today's Date: _____/_____/_____

Parent or Legal Guardian (Please Print)_____

Date of Birth: _____/_____/_____ Age: _____ Gender: Male □ Female □

Address: _____City, State, Zip: _____

Home Phone:_____ Cell Phone: _____ Text OK? Y N Work Phone:_____

SSN: _____-_____-_____ **E-mail Address**: _____

Who may we thank for referring you to All Family Vision Care? _____

Thank you for your visit today!

I understand that you will bill my insurance as a courtesy to me. However, I also understand that I am ultimately responsible for the total amount due, should my insurance company decline to pay or if I do not have insurance. I understand that payment of at least half of my portion of the total bill (including any co-pays) is expected at the time services are rendered and before my glasses or my contacts will be ordered. I authorize my insurance company to make payment directly to the provider. If my insurance company pays me instead of the provider, when the provider should have received the payment, I agree to inform the provider and pay the amount owed in full. I am aware that there is a **$25.00 returned check fee** policy in effect in this office. I understand that if my account is delinquent at 120 days past service date, it may be turned over to collections. Should my account have to be turned over to collections, I agree to be responsible for any extra fees that this office might incur due to such a situation, including a $25.00 processing fee and any and all municipal charges. **All Family Vision Care asks that you notify our office at least 24 hours in advance when you are unable to keep your scheduled appointment. A "no show" will result in a $25 charge to be added to your account.** My signature on this form is acceptance of these terms and may also be used as the signature on file for insurance purposes. If I have any questions regarding any of this information I am free to inquire before my exam and before I place an order. **Signature is required before an exam takes place and before an order is placed**.

_____ _____

Signature Today's Date