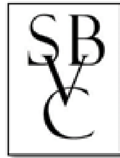

Scottsbluff Vision Clinic
Eastern Wyoming Eye Clinic

THANK YOU FOR CHOOSING US AS YOUR EYE CARE PROVIDER
If you desire assistance completing this form, our staff will be happy to help you.

Name	**IF UNDER AGE 18 OR A STUDENT**
Social Security Number	Father's Name
Birth Date	Employer
Spouse's Name	Mother's Name
Address	Employer
City	**WHOM MAY WE THANK FOR REFERRING YOU TO US?**
State	
Zip Code	**OUR EXCEPTIONAL VALUES**
Employer	2-YEAR WARRANTY on any frame and lens purchase
Occupation	15% CREDIT CARD DISCOUNT if paid in full on day of service
Home Phone	20% CASH DISCOUNT if paid in full on day of service
Work Phone	30% DISCOUNT on 2+ pairs of eyewear if purchased same day
Cell Phone	**CARE CREDIT INSTANT FINANCING**
Email Address	COMPLETE ONLINE APPLICATION **NOW**

I acknowledge below that I have received a copy of Scottsbluff Vision Clinic's Notice of Privacy Practices.

Signature *	Date

LIFETIME MEDICARE/INSURANCE SIGNATURE AUTHORIZATION: I request that payment of authorized Medicare/Medigap/Blue Cross-Blue Shield/other benefits be made either to me or on my behalf to Scottsbluff Vision Clinic for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that insurance may not pay for any or all services rendered in this office. However, I do accept responsibility for payment of these services. A deposit of one-half the total charge is required before materials can be ordered from our laboratory, with the balance due upon dispensing. A finance charge of 1.5% will be charged monthly on any balance outstanding more than 30 days.

Signature *	Date