eyesupply®

Patient's Name _____

Address _____

Town _____ Zip _____

Email _____

Phone (Home) _____ (Work) _____ (Cell) _____

Member's Social Security No. _____

Patient's D.O.B. _____ Member's D.O.B _____

I am interested in: ☐ Eyeglasses ☐ Contact Lenses ☐ BOTH

How Did You Hear About Us? _____

INSURANCE RESPONSIBILITY AGREEMENT

I authorize Eye Supply of Port Jefferson to apply for benefits on my behalf for services.
I understand that all discounts and insurance / union information must be presented at the time of service to use benefits.
If my insurance company fails to pay for a submitted claim for services rendered on my behalf, then I am responsible for payment within 6 months.
Any collection and / or attorney fees will be my responsibility.
I acknowledge that I have received the HIPPA Notice of Privacy Practices of Eye Supply.

Patient's or Guardian's Signature _____ Date _____