



Scottsbluff Vision Clinic  
Eastern Wyoming Eye Clinic



Thank you for choosing us as your eye care provider! We are dedicated in preserving your vision for a lifetime.

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
Mailing Address	Employer
City	WHOM MAY WE THANK FOR REFERRING YOU TO US?
State	
Zip Code	
Employer	<b>OUR EXCEPTIONAL VALUES</b>  2-YEAR WARRANTY on most frame and lens purchases 15% CREDIT CARD DISCOUNT if paid in full on day of service 20% CASH DISCOUNT if paid in full on day of service 30% DISCOUNT on the second, third or more pairs of eyewear purchased on the same day  <b>CARE CREDIT INSTANT FINANCING</b> COMPLETE ONLINE APPLICATION <u>NOW</u>
Occupation	
Home Phone	
Work Phone	
Cell Phone	
Email Address	

I acknowledge 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 \_\_\_\_\_

Checked in by: \_\_\_\_\_