SCOTTSBLUFF VISION CLINIC
— The Eye Care Experts —

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	**OUR EXCEPTIONAL VALUES**
Employer	**2-YEAR WARRANTY** on most frame and lens purchases!
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 the second, third or more pairs of eyewear purchased on the same day!
Cell Phone	**CARE CREDIT INSTANT FINANCING**
Email Address	COMPLETE ONLINE APPLICATION NOW

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: _____