2475 Village Lane, Suite 202, Billings, MT 59102 T. (406) 252-6608 F. (406) 252-6600
111 S. Broadway, #B, Red Lodge, MT 59068 (406) 446-3937
1150 Main St., Lander, WY 82520 (307) 332-5272

Patient's Name_______________________________________Maiden Name:____________________
(last) (first) (middle initial)

Address________________________________City______________________State_______Zip ________

Phone: Home ( ) ____________________Cell ( ) ________________________

Date of Birth________________Age________Sex: [ ] F [ ] M Marital Status: [ ]S [ ]M [ ] W [ ] D

S.S.#_______________________E-mail Address____

Employment status: [ ] Full Time [ ] Part Time [ ] Retired or [ ] Student

Employer Name:____Phone:( ) ______________

Address________________________________City______________________State_______Zip ________

[ ] Spouse [ ]Parent [ ] Guardian [ ] POA (bring documentation) Name ___________________________

S.S.#_______________________Date of Birth_____________E-mail Address_________________

Address________________________________City______________________State_______Zip ________

Phone: Home ( ) ____________________Cell ( ) ________________________

[ ] Parent #2 [ ] Guardian #2 [ ] POA #2 (bring documentation) Name ___________________________

S.S.#_______________________E-mail Address_____________________________________

Address________________________________City______________________State_______Zip ________

Phone: Home ( ) ____________________Cell ( ) ________________________

Whom May We Contact in Event of Emergency?

Name____Relationship__________________________

Phone ( ) ____

Address____

How did you hear about us? [ ] Friend______________________[ ] Doctor [ ] Insurance [ ] Paper

[ ] Radio [ ] Facebook [ ] Internet [ ] Yellow pages [ ] Billboard

Name of doctor who did your last eye exam:__________________________When__________________

Referred here by Dr:____

Primary Care Physician:____Phone #____________________

Consent to Care & Financial Agreement: This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all clinical treatments which in the judgment of my physician, may be considered necessary for care. I authorize The Eye Clinic Surgicenter to settle my insurance claim with the provided insurance company on my behalf. Authorization by all payors to pay all physician benefits directly to The Eye Clinic Surgicenter is hereby granted. I understand and agree that, regardless of my insurance coverage or claim payments, I am financially responsible to The Eye Clinic Surgicenter for all charges, and agree to pay for all services rendered immediately upon demand. In the event of non-payment of any amounts due under this agreement, I agree to pay interest thereon at the rate of 1.5% per month (18% per annum) and to pay reasonable attorney fees and court costs. I further agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the total balance due. Important note: Refractions are seldom covered by insurance companies. Any patient balance will be collected at the time of service.

No Call No Show Policy: We understand that situations arise, but if you fail to contact our office to cancel your appointment at least 24 hours prior, you will be assessed a No Call No Show fee of $40. This fee is out of pocket and will not be billed or covered by any type of insurance.

____ ____________________________________

Signature of Patient or Personal Representative Date