



126 Corporate Drive • Suite A • Houma, LA 70360
985/851-2211 • 800/273-3496

PATIENT INSURANCE FORM

(PLEASE FILL OUT COMPLETELY)

PATIENT NAME: _____
DATE OF BIRTH: ____/____/____ SOC SEC: ____/____/____

*****INSURANCE INFORMATION*****

INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S ADDRESS: (IF NOT THE SAME AS PATIENT)

CITY: _____ STATE: _____ ZIP: _____

GENDER: MALE OR FEMALE

DATE OF BIRTH: ____/____/____ SOC. SEC. #: ____/____/____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT

EMPLOYER OF RESPONSIBLE PARTY: _____

OFFICE POLICY

Please initial, sign, and date

1. _____ All **copays** and **material fees** must be **paid** at the **time of service**. If materials are not paid in full, they **will not be ordered**.
2. _____ I understand that my **insurance may not** always **cover** all of the expenses involved in my eye examination, and **some charges may be billed to me** directly.
3. _____ Our **materials** carry a **30 day grace period**. Returns **after 30 days** are subject to **new charges**.
4. _____ Effective **NOVEMBER 15, 2010**, due to the high shipping cost, contact lenses will not be order until they are paid in full.

To order contact lenses you must:

- **Come in and pay for them by cash, check, or charge.**
- **Call and pay over the phone with a credit/debit card.**
- **Go on our website www.fvchouma.com**

Also, **all balance must be paid in full** before contact lenses are ordered.

5. _____ We appreciate a **24 hour notice** for **cancelled** appointments. If not there is a **\$40 assessment fee**.

Signature: _____

Date: _____

LAWRENCE BREAUX, O.D.

OPTOMETRY

FAMILY VISION CARE • CONTACT LENSES
EYE DISEASE & INJURY