

Entry Form

Insurance Info. (Disregard this section unless asked to fill out)

Name of Insurance: _____ Employer: _____

Member name if not yourself: _____ Member date of birth: _____

Member ID or last 4 of SSN: _____ Relationship to subscriber: _____
(self, parent, etc)

Optical and Contact Lens Policy

*We guarantee our glasses and lenses for at least one year. If there ever is a problem, bring them back and we will adjust, repair or replace as needed.

*We will remake a prescription once if you are having trouble adapting to a prescription.

*If you bring an outside prescription in and are having problem adjusting to the prescription, we will remake the lens if given a new prescription. We can also check your prescription at our

*Contact lens can be returned within 45 days if they are unopened. If they are opened we may be able to provide store credit or apply it to a new contact lens order.

All service and/or exam fees are nonrefundable

Financial Agreement:

Payment is due at the time of treatment. Parents/guardians are responsible for all fees rendered for the treatments of a minor/child. I agree to the optical and contact lens policy. I understand that filing a claim with my insurance company does not relieve me of any responsibility for payment. I authorize the use of my signature on all insurance submissions.

Signature

Date