LAKE MERRITT
OPTOMETRY

Vision Insurance _____ Member

ID#_____

Primary Member_____ Primary's

DOB_____

Medical Insurance_____

ID#_____

Group #_____ Primary

Member_____

Relation to Primary Spouse/ Child /Other _____ Primary's

DOB_____

Primary's SSN_____ Primary's

Employer_____

Secondary Insurance (Please provide information as listed above if you have a secondary

plan)_____

_____

_____

_____

__

Billing Policy

By signing below you are agreeing to pay the amounts your insurance has dictated. You accept responsibility for any overages and copays. In an effort to best assist you we will calculate to the best of our knowledge your

portion prior to placing your order. Any amount that the insurance will not cover after the order has been placed will be a responsibility of the patient. If you are a cash pay patient you will be responsible for paying for your products and services. All copays and payments for services must be paid on date of service. Product payment must be paid prior to your order being placed. There are no refunds for services or glasses. Glasses are a custom made product and cannot be returned. If an issue arises with your frame or lenses we will work with you to resolve the problem, within reason. Contacts may be exchanged or returned so long as boxes are not opened or damaged.

_____

_____

Signature of Patient/ Legal Guardian Date

_____

Printed Name of Patient