Benson/Kent Vision Source

Patient Information:

Patient Name: _____

DOB: _____ Last SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Marital Status: _____ Gender: Male / Female

Employer: _____

Primary Care Physician: _____ Last Eye Exam: _____

Insurance Information:

Vision Insurance: _____

ID#: _____ Group #: _____

Employer: _____

Insured Name: _____

DOB: _____

Relationship: _____

Medical Insurance: _____

ID#: _____ Group #: _____

Employer: _____

Insured Name: _____

DOB: _____

Relationship: _____

Please provide us with your current vision and medical insurance cards.

We will verify your benefits and eligibility. However, verification is **only a review** of your benefits, not a guarantee of payment by your insurance company. **Any balance your insurance company does not pay is your responsibility**.

I authorize my insurance benefits to be paid directly to Benson Vision Source. I also authorize the doctor to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request at any time.

I acknowledge that I have read a copy of the privacy policy for Benson Vision Source. My medical information may be shared within the practice or with other health care professionals.

Out of pocket expenses such as copays, contact lens evaluation fees, and Optomap Retinal Screening fee are due at the time of service.

I understand that glasses are a custom product made to my prescription and specifications. Due to this, payment is taken in full to place any orders. Glasses orders cancelled by the beginning of the next business day will be refunded in full. Orders cancelled after the next business day will be subject to a 50% lens fee and a $25 frame restocking fee. If insurance was used, we will reinstate your benefit.

Signature of Responsible Party: _____ Date: _____