WELCOME

Thank you for trusting us with your eye & vision care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to ask us.

A PATIENT INFORMATION

Date_______________
Patient_______________
Address_______________
City/Town_______________
Email Address_______________
Sex: M ☐ F ☐ Age_____ DOB_________

Single ☐ Married ☐

SS#_______________
Occupation_______________
Employer_______________

Employer Address_______________
____
Employer Phone_______________

Spouse's Name_______________

C PHONE NUMBERS

Home_______________
Work_______________
Cell_______________ ☐ Texting ok

IN CASE OF EMERGENCY, CONTACT:

Name_______________
Relationship_______________
Home Phone_______________
Work Phone_______________

D Protected Medical Information

I authorize release of any medical information to my insurance company, legal counsel, Worker's compensation insurance company or liability insurance company for the purpose of pre-certification or to process my insurance claims. I also authorize the release of my medical records to any physician that is involved in my healthcare.

(Signature)_______________ Date_______

B INSURANCE

Who is responsible for this account?_______________
Relationship to patient_______________
DOB___________ SS#_______________
Insurance Co._______________
Group #_______________
Is patient covered by additional insurance? y ☐ n ☐
Subscriber Name_______________
DOB___________ SS#_______________
Relationship to patient_______________
Insurance Co._______________
Group #_______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I or my dependents have insurance coverage with_______________ and assign directly to **Dr. Robert J. Bolduc** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
(Responsible Party Signature)

____
(Relationship)

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. Robert J. Bolduc** for any services furnished me.
I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.

_______________ _______________
Beneficiary Signature Date

BOLDUC EYE CARE
35 BARRA ROAD, P.O. BOX 544
BIDDEFORD, MAINE 04005
TELEPHONE (207) 284-6651

ROBERT J. BOLDUC, JR., O.D.

ERIC LEHOUILLIER, O.D.

Insurance and Financial Policies

- I agree to pay the estimated co-pay at the time of service. *I understand this is **not** a guarantee of benefits.*
- I understand that you will submit my claim to my primary insurance as a courtesy to me.
- I agree to pay any balance remaining once my insurance claims have been processed.
- I authorize insurance payment directly to Bolduc Eye Care.
- If I am not covered by insurance, I agree to pay for each appointment in full at the time of service with cash, local check, CareCredit, MasterCard, Visa, or Discover Card.

Exchange Policy

- If you are unhappy with your glasses, please notify us within 30 days. Our labs have a strict policy on remakes. They allow 1 remake within 30 days at no cost.
- Any changes after 30 days will be done at 50% of the original cost of the lenses.
- Eyeglasses are custom made for each individual and are considered a medical prescription. They cannot be returned for a **full** refund.
- We will remake your glasses covered under the one-time, no-fault guarantee within 30 days.
- If you are unhappy with your frames, we will allow one re-style within 30 days, otherwise, all sales are final.
- You are welcome to use your own frames for new lenses. However, it is at your own risk. We are not responsible if the lab breaks your frame.
- There will be a minimum $25 fee for all warranty claims on eyeglasses.

Signed:____ Date:______________

Date of Birth:________________________