Mid Columbia Vision Center

415 Washington Street The Dalles, OR 97058 (541) 296-2911

Welcome to Mid Columbia Vision Center. Thank you for choosing us for your eyecare and eyewear needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to verify your personal information that we have on file for you to ensure that it is current and accurate. If you have any questions, please do not hesitate to ask.

□Mr. □Miss □Mrs. □Ms. □Male □Female

_____ _____ _____

First Name MI Last Name

_____ _____

Date of Birth Social Security Number

ACCOUNT RESPONSIBILITY:

_____ _____ _____

First Name MI Last Name

_____ _____

Date of Birth Social Security Number

_____

Relationship to Patient

_____ _____ _____

Mailing Address City & State Zip Code

_____ _____

Phone Number Employer

Please Read: In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Mid Columbia Vision Center. **I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.**

_____ _____

Signature of Patient or Person Authorized by Law Starting Date

Ending Date: **Lifetime**

Revised 03/2013