## FIRESIDE EYE CARE, P.C. WELCOME

Welcome to Fireside Eye Care, P.C. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient. Please take a moment to complete the following information. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask

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I acknowledge that I have had the chance to revier rendered unless other arrangements are made in advance subject to collection fees in addition to the account balar are final. Any returns that are approved may be subject. I authorize payment from my insurance to be paid company and that final determination can only be made my insurance companies. I authorize my doctor to act at of the original.	ce. The undersigned was due. There will be to a restocking fee. directly to Fireside Eye when the claim is proc	vill be responsi a service char e Care, P.C. I essed. I autho	ble for any bill incu ge on all returned understand that al rize the use of this	urred in this office checks. Profession I benefits quoted to form on all insura	regardless of insur anal services are no o me are not a gua ance submissions a	ance. Accounts 90 days old are ot refundable, and all product sales arrantee of payment by my insurance and the release of all information to

Date

Signature