BUTLER EYE CARE, LLC.
297 Evans City Rd.
Butler, PA 16001
Tel (724) 283-8144 FAX (724) 283-7303

CHICORA EYE CARE
Box 550, 104 W. Slippery Rock St.
Chicora, PA 16025
Tel (724) 445-3901 FAX (724) 445-0031

I HAVE BEEN MADE AWARE BY THE ***NOTICE OF PRIVACY PRACTICE (HIPAA)*** THAT BUTLER EYE CARE, LLC/ CHICORA EYE CARE IS REQUIRED TO TAKE CERTAIN MEASURES TO MAINTAIN THE SECURITY OF THESE RECORDS, CERTAIN LIMITS AND PROTECTIONS, FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS ACTIVITIES. I AUTHORIZE TO RECEIVE TREATMENT FOR SERVICES FROM BUTLER EYE CARE, LLC./CHICORA EYE CARE AS WELL AS DOCTORS AND STAFF.

Name of Subscriber *(As it appears on card)*______________________________
Subscriber's Insurance ID# (may be social security #)________________________
Subscriber's Date of Birth:_____________________

Person(s) with whom we may discuss your patient records and/or financial information:
Names:________________________________ Phone #_______________

Emergency contact person:
Name:_________________________________ Phone #_______________

I HAVE AUTHORIZED BUTLER EYE CARE, LLC/CHICORA EYE CARE OR MY INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED IN PROCESSING MY CLAIMS.

I understand and personally guarantee the payment of the balance of Medical/Vision services and/or materials not covered by my medical/vision insurance carrier. The details of the financial transaction have been explained to me by the employee(s) of Butler Eye Care, LLC/ Chicora Eye Care. Upon submission to the medical/vision insurance carrier, I will be notified of my financial obligation to the remaining portion of the unpaid balance and promise to pay this balance with ninety (90) days after being notified. Furthermore, I agree to pay all reasonable cost that may be necessary to collect delinquent and unpaid balances. I understand and have been made aware that Butler Eye Care, LLC/Chicora Eye Care reserves the right to use a collection agency to recover the unpaid costs.

I____Date_______________
(Signature)

Please check & complete your one (1) preference to receive notices from Butler Eye Care regarding appointments, eyeglass or contact lens orders:

- ☐ HOME PHONE:______________________
- ☐ EMAIL ADDRESS:___________________
- ☐ TEXT MESSAGE:____________________

PAYMENT T ERMS AND CONDITIONS

1. When ordering lenses, frame, and/or contact lenses, one-half (1/2) of the total cost is required when all orders are placed.
2. Payments are accepted by cash, credit/debit cards, or personal check. There is a **$50.00** returned check (NSF) fee.
3. There is a 2% service charge added to each statement every 30 days, on any past due balance.
4. There is a $35.00 "No Show" service fee.