INDIANA VISION
Development Center

Carl O. Myers, OD, FCOVD

PAYMENT CONTRACT

Thank you for selecting us for your vision care needs. We want to prevent any misunderstandings regarding our payment policy, therefore, we request that you read and sign this explanation of our policy.

Dr. Myers will honor Cash, Check, Visa, MasterCard, Discover and American Express as payment. The patient is responsible for payment of his/her account at the time services are rendered.

Referral to our professional collection service will be made for accounts older than three (3) months and when the patient has not made firm credit arrangements with our Accounts Manager. In the event of default, I agree to pay late fees, collection costs and reasonable attorney fees as may be required in collecting debt.

The undersigned certifies that he/she has read the forgoing and is the patient, patient's guarantor or duly authorized by the patient's agent to execute this agreement and accept its terms.

Patient_____ Primary Phone_____

Address_____ Date of Birth_____

City/State/Zip_____ Secondary Phone_____

Parent/Spouse/Guardian's Name_____ Alt. Phone_____
(Emergency Contact Not Living at Address Above)

Email Address: _____

Employer Name_____ Work Phone_____

Spouse's Employer_____ Work Phone_____

Insurance Company Name_____ID#_____

Insured's Name_____ Insured's Date of Birth_____

_____ _____ _____
Responsible Party Social Security Number Date

Consent of treatment for minors under the age of 18_____
Parent/Guardian Signature

_____
Office Staff Signature

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