Joseph J Raczek, OD
380 Nashua Street
Milford, NH 03055

Phone: (603) 673-7428
drraczek.com
Fax: (603) 673-5122

Date ___/___/_____

Name_____ ☐Mr. ☐Mrs. ☐Ms ☐Miss
First Last MI

DOB___/___/____ SS#_____ *(optional)*

Address_____City_____State____Zip_____

Home# (___) _____ Work# (____) _____ Cell# ( ) _____

E-mail _____(On-**line contact lens orders offered at a savings)**

Occupation_____ Employer_____

Emergency contact name_____ Phone number (___) _____

Date of last eye exam ___/___/____ Referred by_____

Special vision needs _____

Insurance/Payment Information

Please inform us of any insurance which covers for your routine eye care or eyewear. We are only able to submit claims for the insurances listed below. You are responsible for co-payments, deductibles, or non-covered materials or services. You will be billed for these in accordance with our standard office policies. If your insurance is not listed you will be responsible for the charges. We will gladly assist you with filling out insurance forms so that you may receive reimbursement directly from your insurance company. PLEASE INFORM US OF ALL YOUR INSURANCES AT THE TIME OF YOUR OFFICE VISIT. IF YOU TELL US ABOUT YOUR INSURANCE COVERAGE AFTER THE FACT, PAYMENT WILL BE YOUR RESPONSIBILITY.

Please check your insurance :

☐**Anthem/BC/BS** ☐**Cigna Health Care** ☐**Harvard Pilgrim** ☐**Aetna/US Healthcare**

☐**Vision Benefits of America (VBA)** ☐**United Healthcare** ☐**Health Care Value Management**

☐**Vision Service Plan (VSP)** ☐**Superior Vision Services** ☐**Medicaid / Medicare**

Other/Secondary _____

Your medical insurance will generally pay for medical procedures. However, different rules apply for medical eye care as opposed to routine vision care (referral needed from PCP, etc.) Please note that if your insurance denies payment for any reason, you are responsible for any bills you incur.

Unless prior arrangements are made in advance, our office policies are:

- **Payment for services is due at the time of service.**
- **A deposit of ½ the total cost of materials is required before ordering materials. The balance is due when the glasses/contact lenses are dispensed.**

_____ _____

Patient/Guardian Signature Date

Name_____ **Date___/___/____**