



HOSPITALITY EYECARE
CENTER of OPTOMETRY

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fx 909 383 5010

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San Bernardino, CA 92408

www.seetolive.com

PAYMENT PLAN APPLICATION

WHO CAN TAKE ADVANTAGE of THIS PAYMENT PLAN

Financial Hardship

If you are undergoing any financial hardship and may not be able to afford the cost of treatment, glasses or contact lenses, then this plan may help you spread the cost out, over time. This will allow you to make small affordable payments. You may also qualify for discounts and/or financial assistance. Ask the staff for more information.

Anyone

You may not be "Financial Hardshipped" but every once in awhile we all need help. Anyone can request a payment plan; however, we ask that you only request it if you sincerely need it. All applications must be approved by the doctor. There are no guarantees your request will be approved.

Complete and give to a staff member

Your Full Name _____ Social Security # _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____

Family or Friend's Name _____ Relationship _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Two Credit or ATM Cards Information

Type of Card: VISA MC OTHER _____ (not American Express)

Name on Card _____ Card # _____

Expiration Date _____ 3/4 Digit Code _____

Billing Street Address (if different from above) _____

City _____ State _____ Zip Code _____

Type of Card: VISA MC OTHER _____ (not American Express)

Name on Card _____ Card # _____

Expiration Date _____ 3/4 Security Digit Code _____

Billing Street Address (if different from above) _____

City _____ State _____ Zip Code _____

(FOR OFFICE USE ONLY)

Approved _____ Denied _____ Authorized by _____ Date _____

\$ _____ to be paid per month for _____ months until \$ _____ has been paid.