Advanced Family Eyecare
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Report Request Form

Name: ____________________________________Phone: ____________________

Patient Name: ____

Date: _____________Time: _________ Report needed by (date):_____________

For: ❑ IEP ❑ 504 ❑ School Accommodations ❑ ACT ❑ Progress
❑ Other

Details (please **be as specific as possible** regarding what you would like included in your report): (Example: Testing in a room free of distractions, etc…)

1.____
2.____
3.____
4.____
5.____

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Cost:

Reports for patients of Advanced Family Eyecare cost between $46-$96 depending on the involvement and length of report. Please provide your method of payment below. Payment is due when your report is requested. Fax request to (405) 755-1875 or email to info@afeyecare.com. Please allow 2-3 weeks for report.

Thank you.

❑ Cash ❑ Check

Card: ❑ Visa ❑ MasterCard ❑ Amex ❑ Discover

Card Number: ___________ - __________ - ___________ - ___________

Expiration: _______/_______ Security Code: ____________

Signature: ____

Request taken by: _____________