Insurance Form

Name of Vision Insurance Company _____

Primary Insured's

Name_____

Employer_____

Date of Birth _____Insurance ID# or SSN_____

Primary Insured's Address (If different from Patient's)

_____

_____

Patient Name _____ Date of Birth_____

RESPONSIBILITY STATEMENT •

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

By signing this statement you agree to be financially responsible for all charges.

• AUTHORIZATION TO RELEASE MEDICAL INFORMATION •

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature_____ Date_____