INSURANCE INFORMATION

Financial Responsibility (Insurance)

We will be happy to file your insurance claim or take assignment of your vision and/or medical benefits as designated by your insurance company. We are happy to provide this service without any additional charge to you. We will do all that we can to help you receive the maximum benefits.

We go to great lengths to verify the amount and type of coverage, however, final determination of your benefits will not occur until the insurance company receives your claim. In the event the insurance determines you are not eligible at the time of service, makes a determination that you are eligible for a reduced level of coverage, or applies the charges to your deductible, by signing this statement, you agree to be financially responsible for any and all charges incurred by you and not paid by the insurance, this includes any fees for collections.

Signature____Date___________________

Insurance Company________________________________ ID/Contract #_____________________________

Name of Insured__________________________________ Date of Birth_____________________________

Insured SSN#____________________________________ Relation to patient________________________

Patient Name____________________________________ Date of Birth_____________________________

Patient SSN#_____________________________________

Responsible party information: (For patients under 18 years of age)

Name____ Date of Birth_____________________________

Relationship to patient____________________________ SSN#____________________________________

Address____ City, State, Zip___________________________

Home/Cell Phone #________________________________Work #__________________________________

For Office Use Only:

Authorization date________________ **Authorization #**_____________________________ **Copay**___________

Date filed___________________ **Patient Owes/ Date**________________ **We Owe/Date**___________________

Completed by:_________________________