Insurance Information

Complete the following information for the PERSON that carries the INSURANCE on the patient. The INSURANCE CARD is required at EVERY VISIT and must be provided TODAY to receive any covered benefits.

Patient Name _____ **Patient's Birth Date** _____

Policy Holder Name _____ **Last 4 digits of SS#** _____

Policy Holder Birth Date _____ **Relationship to Patient** _____

Policy Holder Employer _____

Insurance Company _____

Policy or ID Number _____

****AUTHORIZATION OF BENEFITS FOR FILING OF INSURANCE: I request payment of Insurance and/or government benefits to this office that accepts assignments. I authorize lifetime insurance payments of medical benefits to this office for services Received today and for any future visits or services rendered. I authorize the release of Any medical, personal or other information necessary to process this claim.**

*****STATEMENT OF FINANCIAL POLICY:**

***All fees for examinations and office visits are due at the time of the visit.**

***All glasses and contact lenses must be paid in full before you receive them.**

***I acknowledge and accept financial responsibility for this account.**

***I have read and understand the above information.**

X _____ **Date** _____

Patient Signature (If patient is a minor, signature of person financially responsible)

Release of Personal Information

X _____ **Date** _____

Patient Signature (If patient is a minor, signature of person financially responsible)

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____