Patient Financial Information Sheet

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient: ____

Name of Insured: ____

Name of Insurance Carrier: ____

If you have more than one insurance policy, please note which one is primary, secondary etc.

ID#:______________________________________

Policy/Group #:______________________________________

Insurance Card Copied: _____ Yes _____ No _____ No Card

Do you have a separate ***VISION CARE PLAN*** in addition to your medical insurance? **YES** **NO**
If yes, please provide the name of the Vision Care Plan and ID #.
Name of Vision Care Provider______________________________________
ID #:______________________________

I have received or was offered and declined a notice of privacy practices.

Signature:______________________________________ **Date:**________________

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: ______________________________

______________________________________ ________________
Signature of patient or parent if minor **Date**