INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for payment:	Is this person a patient here? Yes No	Birth date:
Address (if different):		Home phone no.: ( )

Primary vision insurance:					
Subscriber's name:			Subscriber's S.S./ID or contract no.:	Birth date:	Group no.:
Patient's relationship to subscriber:	Self	Spouse	Child	Other:	
Secondary vision insurance:					
Subscriber's name:			Subscriber's S.S./ID or contract no.:	Birth date:	Group no.:
Patient's relationship to subscriber:	Self	Spouse	Child	Other	
Primary medical insurance:					
Subscriber's name:			Subscriber's S.S./ID or contract no.:	Birth date:	Group no.:
Secondary medical insurance:					
Subscriber's name:			Subscriber's S.S./ID or contract no.:	Birth date:	Group no.:
Patient's relationship to subscriber:	Self	Spouse	Child	Other	

If you have insurance
We are happy to process any insurance forms for optical or medical benefits you may have as a courtesy to you. However, since we may be in network with your insurance carrier, it is not our policy to contact carriers to establish why they have not paid or why they paid less than anticipated. Please understand that lenses and eye care costs may exceed the insurance payment, and that you will be financially responsible for all charges, whether or not paid by insurance. We do require that your portion of the total cost for professional services be paid in full at the time of your visit. A 50% payment on eyeglass or contact lens orders is required at the time they are ordered.

I have read and understand the above information regarding payment policies and optical/medical insurance.

_____ _____
Signature of Patient/Guardian Date

By signing this, I acknowledge and understand the Notice of Privacy Practices (a standard HIPAA compliant document), which is available upon request.

_____ _____
Signature of Patient/Guardian Date

Additional person(s) who have my permission to view my records:

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