

INSURANCE INFORMATION

(PLEASE PRINT)

Patient Name _____ DOB ____/____/____ Sex M F
Name of Vision Plan _____
Name of Policy Holder _____ Social Security/ID # _____
(if other than patient)
Patient Relationship to Policy Holder: Self Spouse Child
Address _____ City _____ State ____ Zip _____
Name of Policy Holder's Employer _____ Group # _____

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, *please contact your representative*. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not your insurance company's.

If verification for insurance coverage is not available upon visit, all professional fees will be charged at the time of service.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment below.

Signed _____ Date _____
(If patient is under 18 years of age, parent or guardian must sign above).

PRIVACY POLICY ACKNOWLEDGMENT

Before we collect your information, we want to make sure that you are aware of our privacy policy. The policy explains why we collect your information and how it will be used. We have posted our policy in the office and have a copy available if you would like to take one and review it.

Please sign to verify that we have informed you of our policy
and have made a copy available to you.

By signing below, acknowledgment is given of receipt of Image Eyecare's Notice of Privacy Practices.

Signature _____ Date _____

*If signing as a personal representative of the patient,
describe the relationship to the patient and the source of authority to sign this form:*

Print Name Relationship to Patient

**Reason for no signature: Refused to Sign, Unable to Sign, Language Barrier, Etc.
(if applicable insert into Patient's Signature space)*