FAMILY VISION CLINIC
Patient Insurance Form

(PLEASE FILL OUT COMPLETELY)

1. PATIENT NAME: _____

DATE OF BIRTH: _____/_____/_____ SOC SEC: _____/_____/_____

2. HEALTH INSURANCE COMPANY: _____

MEMBER ID#_____

MEMBER'S NAME: _____

MEMBER'S ADDRESS:_____

CITY: _____STATE: _____ZIP: _____

GENDER: MALE OR FEMALE

DATE OF BIRTH: _____/_____/_____ SOC SEC #: _____/_____/_____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT

MEMBER'S EMPLOYER: _____

3. SECONDARY INSURANCE: _____

MEMBER ID#_____

MEMBER'S NAME: _____

MEMBER'S ADDRESS:_____

CITY: _____STATE: _____ZIP: _____

GENDER: MALE OR FEMALE

DATE OF BIRTH: _____/_____/_____ SOC SEC #: _____/_____/_____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT

4. OTHER INSURANCE (VISION)_____

MEMBER ID# _____

MEMBER'S NAME_____

MEMBER'S ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

GENDER: MALE OR FEMALE

DATE OF BIRTH: _____/_____/_____ SOC SEC #: _____/_____/_____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT

SIGNATURE: _____DATE: _____

Privacy Practices
Financial Responsibility and Authorization to Release Medical Information

I (the patient or authorized representative) understand that having insurance is not a substitute for payment. I understand that many companies have fixed allowances or percentages based on my contract with them - not with Family Vision Clinic. I understand that it is my responsibility to pay for the copay, deductible, coinsurance, or any other balances not paid for by my insurance. I understand that Family Vision Clinic will assist me in receiving reimbursement as much as possible, but that I am ultimately responsible for my own bill with the clinic.

I understand that if payment is not made in a timely manner, Family Vision Clinic may find it necessary to place my account with an agency for collection. In this event, I agree to pay any and all fees associated with the collection process.

I understand that Family Vision Clinic will do its best to ensure my vision materials are manufactured to my specifications. However, if this does not occur, I understand that Family Vision Clinic will be glad to provide me with an office credit to be used at any time by me or my dependents. I understand that Family Vision Clinic will not issue refunds for examinations or materials.

In addition, I authorize Dr. Mason Authement and Family Vision Clinic to release to the necessary health care providers and agencies any information needed to determine services required or the benefits payable for related services. This assignment will remain in effect until I revoke it in writing. I understand that a photocopy of this assignment is considered to be as valid as the original.

By signing this agreement, I (the patient or authorized representative) understand and comply with everything stated above.

X _____ X _____

Patient Name (Please Print) **Date**

X _____

Patient or Authorized Representative Signature

Witness Initial (Office Use Only): _____ *Date:* _____