Insurance Information

List name of vision insurance: ____________________
ID#: ____________________
List name of health insurance: ____________________
ID#: ____________________
Policyholder's First and Last name: ____________________
Policyholder's D.O.B: ____________ **Relation:** ____________

I hereby authorize Carolina Family Eyecare to release any information to process this claim. I also authorize my insurance benefits be paid directly to the physician. I acknowledge that all information above is complete and correct. I understand that I am financially responsible for any services not covered by insurance.

____________________ ____________
Sign Date

PLEASE READ:

We make every effort to verify insurance coverage before the patient is seen. In our experience, phone verification does NOT guarantee reimbursement. In such cases we will file and re-file the claim. If the claim is denied after the second attempt in filing a bill will be sent. At that point, you may contact your insurance carrier if you feel that the claim was denied in error.

I acknowledge that I received a copy of the Notice of Privacy Practices, HIPAA.

____________________ ____________
Sign Date

Please list names of anyone we may speak with regarding your records and/or account:
Name: ____________________ **Relation:** ____________
Name: ____________________ **Relation:** ____________
Name: ____________________ **Relation:** ____________

____________________ ____________
Sign Date