INNOVATIONS in EyeCare

Insurance Information

Please note that payment in full for services rendered is due at time of service unless other arrangements have been made.

Patient Information

Name of Patient: _____Date of Birth (mm/dd/yyyy): _____

Insured Party Information

Name of Insured Party: _____Date of Birth (mm/dd/yyyy): _____

Health Insurance Carrier

Name: _____

Identification Number: _____ Policy Number:_____

Secondary Insurance Carrier

Name: _____

Identification Number: _____ Policy Number:_____

Vision Insurance Carrier

Name: _____

Identification Number: _____ Policy Number:_____

Authorization for Release of Health Information

By my signature below, 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 also authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

In addition, 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 the behalf of myself or my dependents.

Signature: _____ Date (mm/dd/yyyy): _____/_____/_____

Payment Policy Agreement

By my signature below I acknowledge that I have received, or was offered but declined, a copy of this office's Payment Policy, and that I agree to abide by its contents.

Signature: _____ Date (mm/dd/yyyy): _____/_____/_____

Acknowledgement of Receipt of Privacy Practices (HIPAA)

By my signature below I acknowledge that I have received, or was offered but declined, a notice of privacy practices.

Signature: _____ Date (mm/dd/yyyy): _____/_____/_____