PATIENT INFORMATION

Date: _____ Email Address: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security Number: _____

Cell Phone: _____ Birthdate: _____ Age: _____ Sex: _____

Work Phone: _____ Emergency Contact Name: _____

Employer: _____ Emergency Phone: _____ Rel: _____

Occupation/Title: _____ Whom may we thank for referring you? _____

PRIMARY INSURANCE HOLDER

Name of Insurance Holder: _____ Rel: _____ SS#: _____

Birthdate: _____ Work Phone: _____

INSURANCE

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

A PHOTO COPY OF YOUR MEDICAL INSURANCE CARD AND YOUR VISION INSURANCE CARD IS REQUIRED AT TIME OF SERVICE

We will submit to the following insurances. Please print the form and circle your current insurance.

BCBS Plans	Choice Plans	Health Partners
Medica Plans	Medical Assistance	Medicare
Minnesota Care	Preferred One	Select Care
Superior Vision (form)	U Care	VSP
Davis	Eyemed	

Several insurance plans need referrals from their Primary Clinic. It is the patient's responsibility to request the referrals for all appointments. If a referral is not received by our office the patient will be responsible for payment at the time of service.

ALL PATIENTS WITH PRIVATE INSURANCE WILL BE RESPONSIBLE FOR FILING THEIR OWN CLAIMS

Patients who carry insurance should remember that professional services are provided and charged to the patient and not to the insurance company. Coverage varies from one company to another and we do not know what may be covered by your particular plan. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

INSURANCE

AUTHORIZATION, RELEASE, AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the optometrist to release any information including the diagnosis and the records of any treatment or examination rendered to me to third party payors and/or other health practitioners.

I authorize and hereby request that my insurance company to pay directly to the optometrist or corporation insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or on behalf of my dependents.

I agree to accept financial responsibility, including all collections costs and reasonable attorney's fees. There will be at 1.5% interest charge per month on all balances over 60 days.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature of Patient or Parent Guardian of Minor: _____ Date: _____