CASCADE EYE CENTER

Insurance Information

Patient Name: _____ Date: _____
FIRST M.I. LAST

MEDICAL Insurance

Primary Medical Insurance: _____ Group #_____ ID#_____

Subscriber: _____ DOB: _____ SS#: _____

2nd Medical Insurance: _____ Group # _____ ID# _____

Subscriber: _____ DOB: _____ SS#: _____

VISION Insurance

Primary Vision Insurance: _____ Group #_____ ID#_____

Subscriber: _____ DOB: _____ SS#: _____

2nd Vision Insurance: _____ Group #_____ ID#_____

Subscriber: _____ DOB: _____ SS#: _____

SUMMARY - FINANCIAL POLICY

INSURANCE BILLING and PAYMENTS: We verify and bill your insurance as a courtesy. However, insurance verification is not a guarantee of payment. copies of insurance cards, name, and birth date of insurance subscriber for each family member at each visit are necessary for accurate and timely insurance billing.

PAYMENT: All fees for services not covered and/or paid by insurance including co-payments and deductibles will be the responsibility of the patient or responsible party at the time services are rendered. Cash, check, money orders, VISA, MasterCard, American Express, and Discover are also accepted. Care Credit is provided as a financing option.

I hereby authorize Cascade Eye Center LLC or their designee(s) to exchange information regarding my care and benefits with the above listed insurance company or companies for the purchase of collecting professional fees on my behalf. I assign all benefits payable to Cascade Eye Center. To the best of my knowledge this information is accurate as of this date. I accept full responsibility for all charges related to my treatment that are not covered by my insurance.

Signature of Patient/Guardian: _____ Date: _____
(or responsible party)

Revised 10/7/2013