FAMILY VISION CLINIC

Patient Insurance Form

(PLEASE FILL OUT COMPLETELY)

1.PATIENT NAME: _____

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

**********INSURANCE INFORMATION**********

2.HEALTH INSURANCE COMPANY: _____

MEMBER'S NAME: _____

MEMBER'S ADDRESS:(IF NOT THE SAME AS PATIENT)

_____

CITY: _____STATE: _____ZIP: _____

GENDER: MALE OR FEMALE

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

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT

MEMBER'S EMPLOYER: _____

3.VISION INSURANCE: _____

IF INFORMATION IS THE SAME AS ABOVE CHECK HERE

MEMBER'S NAME: _____

MEMBER'S ADDRESS:(IF NOT THE SAME AS PATIENT)

_____

CITY: _____STATE: _____ZIP: _____

GENDER: MALE OR FEMALE

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

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT

Materials and Insurance Office Policies

1. All **copays** and **material fees** must be paid at the **time of service**. If materials are not paid in full, they **will not be ordered**.
2. I understand that my **insurance may not cover** all of the expenses involved in my eye examination, and **some charges may be billed to me** directly.
3. Our **materials** carry a **30 day grace period**. Returns after 30 days are subject to **new charges**.

I understand and agree with these policies of Family Vision Clinic.

SIGNATURE: _____

DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOSE) AND UNDERSTOOD THE NOTICE.

_____ _____

PATIENT NAME (PLEASE PRINT) ***DATE***

_____

PATIENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

_____

SIGNATURE

Financial Responsibility Statement

Your insurance is a method for you to receive reimbursement for fees you have paid to our office for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

A finance charge of 2.5% per month will be applied to any unpaid balance after 30 days. If payment is not made in a timely manner and should this office find it necessary to place your account with an agency for collection, you agree to pay collection fees of 50% of the amount owed at the time of placement. In addition, you also agree to pay any and all court costs and attorney fees at the rate of 33.3% or $75.00 whichever is greater, on any balance due and owing.

We will do our best to ensure your vision materials are manufactured to your specifications. However, if this does not occur, we will be glad to provide you with an office credit to be used anytime by you or your dependents. We do not refund fees for examinations or materials.

By signing this statement you agree to be financially responsible for all charges.

Patient Signature _____ Date _____

Authorization to Release Medical Information

I authorize Dr. Lawrence Breaux 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 revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature _____ Date _____

Witness _____ Date _____

For your convenience, we accept cash, checks, and all major credit cards.

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