

# Academy Contact Lens Clinic

## Patient Financial Information Sheet

I understand that payment in full is due at the time of service unless other arrangements have been made.

Name of Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Card Copied: Yes \_\_\_\_\_ No \_\_\_\_\_ No Card

If no insurance card is available please supply the following information:

Insurance Company: \_\_\_\_\_

Group#: \_\_\_\_\_ ID# \_\_\_\_\_

### AUTHORIZATION AND RELEASE:

I understand it is my responsibility to provide correct and updated insurance information and will be responsible for all charges incurred due to incorrect information.

I understand that I am responsible for the payment of all procedures and treatments not covered by my insurance for myself and/or my dependants.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependants during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my dependants to: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient/responsible party

\_\_\_\_\_  
Date

**FORM REVIEW:** Date/ Initial: \_\_\_\_\_ Date/ Initial: \_\_\_\_\_

Date/ Initial: \_\_\_\_\_ Date/ Initial: \_\_\_\_\_

Date/ Initial: \_\_\_\_\_ Date/ Initial: \_\_\_\_\_

Date/ Initial: \_\_\_\_\_ Date/ Initial: \_\_\_\_\_

Date/ Initial: \_\_\_\_\_ Date/ Initial: \_\_\_\_\_