Insurance Information

Vision Insurance

Name / Type of insurance _____ Group # _____ Employer # _____

Name of insured_____ Relationship to patient _____

Date of birth _____ Social Security Number _____-_____-_____

Name of employer _____ Work phone # _____

Medical Insurance

Name / Type of insurance _____ Group # _____ Employer # _____

Name of insured_____ Relationship to patient _____

Responsible Party

Complete this section only if someone other than the patient is responsible for this account.

Name of person responsible for this account _____

Social Security Number _____-_____-_____

Address (if different from patient's address) _____

City _____ State _____ Zip _____

Name of Employer _____ Work phone # _____

Notice of Privacy Practices

I have received and reviewed Drs. Mark and Suzanne Boas' policy regarding the use of my protected health information in their "*Notice of Privacy Practices"*.

Signature of patient (or parent if a minor) _____ Date _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge and the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Drs. Mark and Suzanne Boas to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Drs. Mark and Suzanne Boas insurance benefits otherwise payable to me. I agree to be responsible for and pay directly to Drs. Mark and Suzanne Boas any charges not covered by my insurance coverage. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that a 1.5 % per month charge will be added to all balances over 30 days in addition to late fees. I further understand that all delinquent accounts (over 120) days will be sent to collection and I will incur the costs involved.

Signature of patient (or parent if a minor) _____ Date _____