WILL YOU BE USING VISION INSURANCE ? Yes or No

Name of Insurance ____

Subscriber Name _________________________Birthdate________________

Subscriber ID Number____

If insurance is VSP, please provide last 4 digits of subscriber's social security

number__________________

Patient's Relationship to Subscriber (Circle) Self Spouse Dependent

Name of Medical Insurance ____

Subscriber Name _______________________________ Birthdate________________

Subscriber ID #_________________________________ Group #___________________

Patient's Relationship to Subscriber (Circle) Self Spouse Dependent

Please Present your Insurance Cards

At this office we practice full-scope optometry and our doctors are not only providers for vision plans, but they are also providers for medical care related to your eyes. This includes disease management, conjunctivitis, foreign body removal, etc. By obtaining your medical insurance now and verifying that we are an in-network provider, it allows us to submit any claims for treatment the doctor deems necessary for your eye health through your medical insurance. Vision coverage is utilized to determine a prescription for glasses, to help pay for eyeglasses or contact lens, and to evaluate the general health of the eyes. It is not designed to deal with MEDICAL conditions and the treatment plan, and necessary follow- up visits related to these conditions. Examples of MEDICAL conditions would be eye diseases and disorders such as infections, dry eyes, allergies and cataracts.

I understand that any questions regarding plan benefits and associated co-pays and deductibles must be directed and resolved by the plan administrator. I hereby release all information pertaining to any insurance claim to all parties concerned. I agree to pay any charges incurred that my insurance carrier determines to be my responsible, such as the amount prior to my deductibles being met and co-pays.

Patient Signature____ Date__________________