INSURANCE INFORMATION

Patient Name:

Please give your vision and medical insurance cards to the receptionist to copy.

Policy holder's name:	Birth date: / /	Policy holder's SSN.:	Relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Please indicate **primary** insurance

❑VSP ❑Eyemed ❑Medical Mutual ❑ Aetna ❑ Medicare ❑ Humana ❑ Anthem
❑ Cigna ❑Medicaid ❑United Healthcare ❑ Other: _____

FINANCIAL AGREEMENT

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance, any account 90 days past due are subject to collections fees. There will be a service charge on all returned checks.

Payment from my insurance company is to be paid directly to Uptown Eye Care, LLC. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that f determination can only be made when the claim is processed.

Patient or Guardian Signature _____ Date _____

AUTHORIZATION TO OBTAIN INFORMATION

Is there a friend or relative authorized to obtain protected health information about you?

Name and relationship of authorized person(s)_____ _____

Name and relationship of authorized person(s)_____ _____

Name and relationship of authorized person(s)_____ _____

HIPAA

I have been offered a copy of Uptown Eye Care's HIPAA Policy.

Patient or Guardian Signature _____ Date _____