INSURANCE INFORMATION AND SIGNATURE ON FILE FORM

Patient Name: _____ Today's Date_____
How did you hear about us? (circle one) Newspaper Radio Yellow Pages TV Referred By: _____
Occupation:_____ Marital Status: (circle one) Single Married Widowed
Emergency Contact_____ Phone: _____
Parent/Guardian_____ Phone: _____

You are responsible for all charges if you do not get prior approval from your insurance company or necessary referrals. You will be asked to pay for any non-covered services, co-payments, and deductibles at the time of your visit. It is your responsibility to verify that we are on your insurance company's participating provider list. We will gladly file your information to your insurance company for payment, but it is ultimately your responsibility for payment in full. The doctor's professional fees are due at the time of service. Payment can be made by cash, check, Visa, Master Card or Discover Card.

We Greatly appreciate your cooperation so we can offer you Better Vision Care!!!!!

(Please notify us if you have a secondary or other insurance)

Insurance Company: _____
Employer #: _____
Insurance Number: _____
Group Number: _____
Insured Name (if not patient): _____ Date of Birth: _____
Relation of Insured to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____

I authorize the release of medical or other information to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment (Box 12). I authorize payment of medical benefits to the undersigned physician or supplier for service (Box 13).

Signature of Patient: _____ Date: _____