INSURANCE INFORMATION

Attention All Patients

Payment is due at the time of service.

Method of payment: □ Cash □ Check □ Credit Card: MC/ Visa/ Discover

Insurance Information – Please present current insurance card

Name of Insurance Company: _____

Secondary Insurance Company: _____

Please complete if patient is not the primary insurance policy holder

Primary Policyholder Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____ Race: _____

We must emphasize that as a medical provider our relationship is with you, the patient and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. **It is your responsibility to know and understand your insurance benefits covered by your insurance company**.

Co-payments, coinsurance and/ or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid, your claim, regardless of our estimation.

Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers with your insurance company, you are responsible for payment due at time of service.

It is your responsibility to provide us with your most current insurance information including copy of your current insurance card and a current referral if needed from your Primary Care Physician. We need to have the referral before you are seen. If not, your appointment will be rescheduled.

Assignment of Insurance Benefits

Medicare/ Other Insurance

I hereby assign benefits to be paid, on my behalf, to North Texas Center for Sight for any services furnished to me. I authorize any holder of medical information about me to be released to the Centers for Medicare and other insurers and its agents any information needed to determine these benefits payable for related services. I understand that I am responsible for my bill in the event Medicare or my insurer denies my claim. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third party payer. I certify the information given with regard to insurance coverage is correct.

Date: _____ Signature: _____