

INSURANCE INFORMATION AND POLICIES Capital Eye Physicians & Surgeons LLC

Primary Insurance Company Name _____

ID or Policy Number _____ Group/Code _____

Insurance Co Address _____

Policy/Subscriber's Name _____ DOB _____

Policy/Subscriber's Home Phone # _____ Soc. Sec # _____

Policy/Subscriber's Employer _____

Policy/Subscriber's Employer Address _____

Policy/Subscriber's Work Phone _____ Relationship to the patient _____

Secondary Insurance Company Name _____ - _____

ID or Policy Number _____ Group/Code _____

Insurance Co Address _____

Policy/Subscriber's Name _____ DOB _____

Policy/Subscriber's Home Phone # _____ Soc. Sec # _____

Policy/Subscriber's Employer _____

Policy/Subscriber's Employer Address _____

Policy/Subscriber's Work Phone _____ Relationship to the patient _____

Our policy is payment is to be made at the time services are rendered, such as (co-pays, non-covered services or unpaid balances). We will file all necessary paperwork with your insurance plan for reimbursement of plan-covered treatments and services. Any treatments or services not covered by your insurance plan will be billed directly to you. Whether or not your insurance pays in full, a portion, or nothing at all for the services rendered, is a matter between you and your insurance carrier. Payment is due within 30 days from the date of your billing statement.

I, agree to promptly pay all charges when billed for medical services rendered and the persons listed above agree and do hereby become legally responsible for any and all charges incurred for the patient named above. Furthermore, the undersigned agrees to pay interest pay interest at 15% APR on any unpaid balance.

I HAVE READ AND AGREE TO THE PAYMENT TERMS AS OUTLINED ABOVE _____ (PATIENT'S INITIALS)

I, hereby authorize Capital Eye Physicians & Surgeons, LLC to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as indicated above, to be made directly to Capital Eye Physicians & Surgeons LLC (or in case of Medicare Part B benefits, to myself or to the party who accepts assignment).

I, certify that the information I have reported with regard to my personal, health information and insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the named billing agent, (or in case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration).

I, permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the named carrier at any time in writing.

Sign _____ Date _____

Sign _____ Date _____

Sign _____ Date _____