

# INSURANCE INFORMATION

**Patient** Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

**DO YOU HAVE ROUTINE EYE EXAM COVERAGE (VISION)?** YES \_\_\_\_\_ NO \_\_\_\_\_

**Insurance Co** \_\_\_\_\_ **Policy#** \_\_\_\_\_

**DO YOU HAVE MEDICAL INSURANCE COVERAGE?** YES \_\_\_\_\_ NO \_\_\_\_\_

**DEDUCTIBLE AMOUNT \$** \_\_\_\_\_ **APPROX. HOW MUCH HAS BEEN USED? \$** \_\_\_\_\_

IF YES, PLEASE COMPLETE FOR THE **PRIMARY INSURANCE POLICYHOLDER:**

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

DOB \_\_\_\_\_ Relationship to patient \_\_\_\_\_ SS# \_\_\_\_\_

Insurance co. \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Employer \_\_\_\_\_ Phone# \_\_\_\_\_

PLEASE COMPLETE THE FOLLOWING FOR **SECONDARY INSURANCE POLICYHOLDER:**

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

DOB \_\_\_\_\_ Relationship to patient \_\_\_\_\_ SS# \_\_\_\_\_

Insurance co. \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Employer \_\_\_\_\_ Phone# \_\_\_\_\_

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## FINANCIAL ASSIGNMENT AND AGREEMENT:

1. I authorize Felton, Wong, Wong and Reynolds, PA to file insurance claims on my behalf and accept assigned benefits when appropriate. I also authorize release of any information to determine these benefits by the insurance company.
2. **IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT AND CO-INSURANCE.**
3. There are certain services, which are not covered by any insurance such as cosmetic procedures and routine eye examinations (unless I have vision coverage). **I understand that I will be responsible for payment for such non-covered services.**
4. Medicare does not consider a routine eye exam or a refraction (a necessary part of an eye exam to determine need for glasses) to be medically necessary, therefore, Medicare does not cover these services. I am expected to pay for these services at the time of checkout.
5. If my account is assigned to a collection agency, **I will be liable for any and all costs of collection.**
6. This agreement will remain in effect until revoked by me in writing.

SIGNED (PATIENT OR PARENT IF MINOR) \_\_\_\_\_ DATE \_\_\_\_\_

PRINTED NAME \_\_\_\_\_