CONTACT LENS ASSOCIATES
MEDICAL AND VISION INSURANCE INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICAL INSURANCE

PRIMARY MEDICAL INSURANCE COMPANY:_____

IDENTIFICATION NUMBER: _____ **GROUP NUMBER:** _____

NAME OF PRIMARY INSURED: _____ **DATE OF BIRTH:** _____

PATIENTS RELATIONSHIP TO THE PRIMARY INSURED: _____

ADDITIONAL MEDICAL INSURANCE COMPANY: _____

IDENTIFICATION NUMBER: _____ **GROUP NUMBER:** _____

NAME OF PRIMARY INSURED: _____ **DATE OF BIRTH:** _____

PATIENTS RELATIONSHIP TO THE PRIMARY INSURED: _____

VISION INSURANCE

PRIMARY VISION INSURANCE COMPANY: _____

IDENTIFICATION NUMBER: _____ **GROUP NUMBER:** _____

NAME OF PRIMARY INSURED: _____ **DATE OF BIRTH:** _____

PATIENTS RELATIONSHIP TO THE PRIMARY INSURED: _____

ADDITIONAL VISION INSURANCE COMPANY: _____

IDENTIFICATION NUMBER: _____ **GROUP NUMBER:** _____

NAME OF PRIMARY INSURED: _____ **DATE OF BIRTH:** _____

PATIENTS RELATIONSHIP TO THE PRIMARY INSURED: _____

- **I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS**
- **I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES**
- **I UNDERSTAND THAT I AM RESPOSIBLE FOR MY BILL**
- **I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES**
- **I AUTHORIZE PAYMENT DIRECT TO MY DOCTOR**
- **I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL**

_____ _____

PATIENT SIGNATURE (PARENT/GUARDIAN IF A MINOR) **DATE**

(OVER)

CONTACT LENS ASSOCIATES
INSURANCE AND PAYMENT POLICY

After you schedule your exam, when possible, we make every attempt to obtain Verification and Pre-Authorization of your Insurance Benefits from your Insurance Company. However, VERIFICATION AND PRE-AUTHORIZATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT BY YOUR INSURANCE COMPANY. Unless, prior to your visit, a specific alternate payment plan is mutually agreed upon and documented, payment in full for all professional services and materials is ULTIMATELY YOUR RESPONSIBILITY.

If your insurance company fails to pay us within 90 days from the date of services and/or materials are rendered, we will bill you directly for any outstanding balance. By signing this form, you agree that you will pay the remaining balance in full upon receipt of our bill.

I have read the above payment policy and understand and agree that after 90 days I am responsible for any amount outstanding and unpaid. I also understand that I may seek further reimbursement directly from my insurance company if I feel additional unpaid benefits are due me. Furthermore, I understand that submitting insurance claims is a courtesy provided by Dr. Schatz and Contact Lens Associates for my benefit, and by signing below I further agree to allow all benefits payable for my services and materials be paid directly to Contact Lens Associates/Dr. Stuart D. Schatz.

_____ _____

Signature of Patient/Guardian **Date**

(OVER)