BISSELL Eye Care

To be seen in a timely manner, please find out which vision insurance company you carry. Come to the office early to insure we have all necessary information, along with your insurance cards.

Vision Insurance: _____ ID#_____
(VSP, VBA, Davis, EyeMed, etc.) (Some vision plans have no card)

Policy Holder's Name: _____ DOB: _____

Policy Holder's Phone #: _____ SS#: _____

Policy Holder's Address:_____ _____
(With some insurance, we need the SS# to get the authorization)

Medical Insurance: _____ID#_____
(Highmark, UPMC, CIGNA, United HealthCare, Medicare, etc.)

Policy Holder's Name: _____ DOB: _____

Policy Holder's Phone #: _____ SS#: _____

Policy Holder's Address:_____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents to any third payer and/or other health care practitioner involved in my care.

I authorize and request my insurance company to pay Bissell Eye Care, LLC directly for services rendered.

I understand my insurance plan may pay less than the actual bill for services; therefore, I agree to be responsible for any payment beyond what my insurance company determines to be the maximum benefit provided.

_____

Patient/Guardian Signature Date