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, <u>along with your insurance cards.</u>

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. If for whatever reason my insurance company denies payment to Bissell Eye Care, LLC, I understand that I am responsible for the balance.

____ __________________

Patient/Guardian Signature Date