

INSURANCE INFORMATION

Primary Insurance

Policy Holder's Name _____ Ins Co Name _____
Policy Holder's ID # _____ Group # _____
Birth date _____ SS # _____ Employer _____

Secondary Insurance

Policy Holder's Name _____ Ins Co Name _____
Policy Holder's ID # _____ Group # _____
Birth date _____ SS # _____ Employer _____

Other Insurance

Policy Holder's Name _____ Ins Co Name _____
Policy Holder's ID # _____ Group # _____
Birth date _____ SS # _____ Employer _____

FINANCIAL RESPONSIBILITY & INSURANCE RELEASE / ASSIGNMENT

I hereby authorize Bond Eye Associates/Alliance Eye Care to release to my insurance company any information including the diagnosis and the records of any treatment or examination, as well as any optical services, rendered to me. **For billing purposes, I understand and authorize the following:**

- Direct my insurance company to issue all payments directly to Bond Eye Associates/Alliance Eye Care.
- Any money received from my insurance company over and above my indebtedness will be refunded to me when my account is paid in full.
- I shall be financially responsible for charges regardless of my insurance benefits and for services not covered or paid by my insurance company.
- I shall be responsible for payment in full for any charges related to services provided without a referral authorization being obtained from my insurance company.
- I shall be responsible for payment in full for any charges related to services provided by a physician who is not part of my insurance plan's network.
- I shall be responsible for added collections charge of one-third my balance, any additional collection charges, legal fees and attorney fees should my account need to be sent to an outside collection agency or when court action is required.

Date: _____ Signed:  _____

Date: _____ Witness: _____

MEDICARE RELEASE AND ASSIGNMENT

I request that payment of authorized Medicare benefits be made on my behalf to Bond Eye Associates/ Alliance Eye Care for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Date: _____ Signed:  _____

SECONDARY INSURANCE

I request that payment of authorized insurance benefits paid by my insurance company be made to either me, or on my behalf, to Bond Eye Associates/ Alliance Eye Care for services furnished. This authorization is valid for all services furnished until it is revoked.

Date: _____ Signed:  _____