



**GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST**

**Insurance Information:**

**Primary Insurance** \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ Group # \_\_\_\_\_

**NOTE: IF THE NAME OF THE POLICY IS OTHER THAN THE PATIENT PLEASE COMPLETE THE FOLLOWING INFORMATION.**

Subscriber/ Owner \_\_\_\_\_ Relation to patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Policy # \_\_\_\_\_

Address \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber/ Owner \_\_\_\_\_ Relation to patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PLEASE READ AND SIGN THE STATEMENT BELOW**

I request that assignment of my healthcare insurance benefits be made to Dr. Elizabeth Mitchell for any services furnished to me. I authorize the release of any medical information necessary to process these claims.

X \_\_\_\_\_ Date \_\_\_\_\_

I understand that I, the patient or patient representative is responsible for payments of charges for services rendered. Past due accounts and returned checks will be subject to collection charges, penalties, and interest.

X \_\_\_\_\_ Date \_\_\_\_\_

**MEDICARE PATIENTS ONLY**

In order to decide if glasses are necessary and to get the correct prescription you must be refracted. The fee for this service is \$25.00. Medicare and most supplements will not cover this. You will be responsible for this fee on the date of service.

I understand and agree with the above information.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_