

Southwest Vision Center's

Insurance / Office Policy Information

** PLEASE COMPLETE ENTIRE FORM **

Patient's Information

Patient's Name: _____ Last _____ First _____ MI _____ Gender: M / F
Patient's Relationship to Insured: Spouse / Child / Self Marital Status: S / M / D / W
Full Time Student: Yes / No (If Yes) Name of School: _____ State: _____
Patient's Employer/Occupation: _____
Insured's Name (If Not patient): _____ DOB: ____ / ____ / ____ Gender: M / F
Insured's Social Security #: _____ - _____ Age: _____ Marital Status: S / M / D / W
Insured's Employer: _____ Work Phone #: (____) _____ - _____
Health Ins. Company: _____ (Have copy of insurance card)
Vision Insurance: _____ (Have copy of insurance card)

Secondary Insured's Information

Policy Holder's Name: _____ Last _____ First _____ MI _____ DOB: ____ / ____ / ____ Gender: M / F
Policy Holder's Social Security #: _____ - _____ Age: _____ Marital Status: S / M / D / W
Insured's Employer: _____ Work Phone #: (____) _____ - _____
Secondary Ins. Comp: _____ (Have copy of insurance card)

Notice:

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies! Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. All eye wear (glasses and/or contacts) must be paid in full before ordered. Any co-payments are due at the time of services. I understand that I am responsible for any balance my insurance does not pay.

(Signature of Patient or responsible party)

Date

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Mario J. Contaldi, O.D.'s "Notice of Privacy Practices" to read.

(Signature of Patient or responsible party)

Date