

Insurance Information

Date: _____

Name of Patient: _____

Patient's Date of Birth: _____

Information provided will be used only for validation and filing of claims for insurance. These are the types of insurance accepted at this office. Insurance information must be provided by patient at the time services are rendered. No compensation will be made for insurance not provided at that time. Please check the one that applies to you.

Name of Insurance Company:

- Aetna* (please see note below)
- Blue Cross Blue Shield
- Cole Managed Vision
- Lumenos
- Vision Care Plan (VCP)
- Vision Service Plan (VSP)
- Medicare Part B
- Wausau Benefits

Name of Subscriber or Policy Holder: _____

Patient's Relationship to Policy Holder Self Spouse Child Other

Policy Holder's Social Security Number or ID # (*Required for Insurance Verification*): _____

Policy Holder's Date of Birth: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy laws.

Signature of Patient _____

Parent or Guardian (if patient is under 18 years of age) _____

**For routine exam - No materials- Medical office visits may require physician referral*