GREAT LAKES VISION CARE

Patient Financial Information Sheet

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient: ______________________________________ DOB: ___________________

Name of Insured: ______________________________________ DOB: __________________

Name of **MEDICAL** Insurance Carrier: ____

Name of **VISION** Insurance Carrier: ____

Insurance Card Copied: Yes ______ No ______ No Card _____

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 child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services.
I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I **DECLINE** access to my electronic prescription history **Initial** ___________

I authorize the release of any information of treatment or examination rendered to me or my child to: ____

(Please list the names of family members or health care providers)

HIPPA Privacy Practice acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature: ______________________________ Date: ________________