





# CASCADE EYE CENTER

## INSURANCE INFORMATION:

If the patient is covered by insurance, the following information must be completed:

Patient: \_\_\_\_\_

### MEDICAL INSURANCE INFORMATION

Primary Medical Insurance: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

2<sup>nd</sup> Medical Insurance: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

### VISION INSURANCE INFORMATION

Primary Vision Insurance: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

2<sup>nd</sup> Vision Insurance: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

### SUMMARY – FINANCIAL POLICY

**INSURANCE BILLING:** We verify and bill your insurance as a courtesy. However, insurance verification is not a guarantee of payment. Copies of insurance cards, name, and birth date of insurance subscriber for each family member at each visit are necessary for accurate and timely insurance billing.

**PAYMENT:** All fees for services not covered and/or paid by insurance including co-payments and deductibles, will be the responsibility of the patient or responsible party at the time services are rendered. Cash, check, money orders, Visa, MasterCard, American Express, and Discover are also accepted. Care Credit is provided as a financing option.

**EFFECTIVE MAY 1<sup>st</sup>, 2009** all medical providers must comply with the new Red Flag Laws, these laws are intended to protect patients from Identity Theft. We will now be asking our patients for photo ID at registration and scanning this ID into the medical record. We will make every effort to verify your identity at each consecutive appointment.

Thank you for your cooperation, we will do everything we can to protect your identity.

I hereby authorize Cascade Eye Center, LLC or their designee(s) to exchange information regarding my care and benefits with the above listed insurance company or companies for the purpose of collecting professional fees on my behalf. I assign all benefits payable to Cascade Eye Center. To the best of my knowledge this information is accurate as of this date. I accept full responsibility for all charges related to my treatment that are not covered by my insurance.

Signature of patient (or responsible party) \_\_\_\_\_ Date \_\_\_\_\_