Appointment date

American Family Vision Clinc: Insurance Information Form

INS17-1

Patient's information:

Last name | MI | First name

Address | City | State | ZIP

DOB | Phone | Cell | Work

If patient is a **minor:** parent's name

If patient is **married:** spouse's name

Person responsible for bill: (This person may receive billing statements containing personal health information)

☐ If same as patient, please check here. If different, what is the relation to the patient?

Last name | MI | First name

DOB

Mailing address:

Address | City | State | ZIP

Primary insurance coverage:

Insurance Company

Subscriber Name | DOB

Subscriber/Member # | Group #

Subscriber Employer

Secondary insurance coverage (if applicable):

Insurance Company

Subscriber Name | DOB

Subscriber/Member # | Group #

Subscriber Employer

By signing this form you are telling us that you or the patient you are accompanying are eligible for benefits with your insurance company or you plan to self-pay. If goods or services are denied or are not covered by your insurance, **YOU** will be responsible for the amount not covered by your insurance. These may include, but are not limited to eye exams, glasses, contact lenses, contact lens evaluations, office visits, vision therapy, photos, visual field testing, sensorimotor evaluations, developmental testing, visually evoked potentials, electroretinograms, pachymetry, gonioscopy, etc. If your insurance is in the process of being terminated you are also agreeing to pay for goods and services provided. If you are behind on paying your premiums, some insurances have a grace period (usually about 3 months.) If goods and services are not covered during this grace period, you are agreeing to pay for them. During your exam the doctors may find it necessary to do additional testing that is not part of a routine eye exam and therefore not covered by vision insurance. These tests must be billed to your medical insurance instead. If you have not met your deductible we will send you a statement

I understand the terms listed above and agree to them.

Signature X_____ Date: _____

Payment Options: **Cash, Check, Visa, Mastercard, Discover, Care Credit, FSA**