Insurance Information

Who is responsible for this account?_____

Relationship to Patient _____SS#_____

Primary Insurance Company_____

Subscriber Name_____Birth Date_____

Is patient covered by additional insurance? ____Yes ____No

Secondary Insurance Company_____

Subscriber Name_____

Relationship to Patient_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to EnVision Family Eyecare all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____	_____
Responsible Party Signature	Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to EnVision Family Eyecare for services furnished me by EnVision Family Eyecare. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. **I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form**, or elsewhere on other approved claim forms or electronically submitted claims, **my signature authorizes releasing of the information to the insurer or agency shown**. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____	_____
Beneficiary Signature	Date