Vision Source Prescott

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_____

If No Insurance Card is Available please supply the Insurance Carrier and ID #

Name of Insurance Carrier: _____

ID#:_____ Policy #:_____

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.

Our office does not guarantee that your Insurance will pay. We will make every attempt in obtaining verification of your policy coverage. However, if for any reason your claim is denied, you are responsible for the full amount of your bill.

Our office will not enter a dispute with your Insurance Company over a claim. This is your responsibility and obligation.

_____ _____

Signature of patient or parent if minor Date