Horner Family Eyecare

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: _____ **Date of birth:** _____

Name of Insured: _____ **Date of birth:** _____

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 in 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 authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or

my child to: _____

Signature of patient or parent if minor: _____ Date: _____

HIPAA Privacy Practice acknowledgement

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

Signature: _____ **Date:** _____

Revised 8/1/2006