INSURANCE INFORMATION

Primary Insured ***if not yourself*** _____
Last Name First Name Initial

Relation to Patient _____ Birth date _____ Social Security # _____

Address _____ Phone _____

City _____State _____ Zip _____ Employer_____

AUTHORIZATIONS

I, the undersigned, have insurance with _____
Name of Insurance Company

and assign directly to EyeQ Optical all medical benefits, if any, otherwise payable to me for services rendered. **I understand that during my exam, medical issues may be found that require medical testing and that my medical insurance may be billed**. I ***understand that I am financially responsible for all charges whether or not paid by insurance. A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

X_____ X_____
Signature or Insured/Guardian Date

Office Use Only			
Vision		**Medical**	
Name of Rep:	Date:	Name of Rep:	Date:
Exam-	copay	Office Visit-	copay
Frame-$	**Eligibility**		
SV-$	Exam		VF (92083)
BI-$	YES NO	Deductible-$	Photos (92250)
TRI-$	Hardware	Met-$	OCT (92133)
Contacts-$	YES NO		OCT (92134)