Patient Information

Name:_____ Birth Date:_____
Social Security #:_____ Phone #:_____
Address:_____

Primary Insurance

Policy Holder:_____ Relationship to patient:_____
Birth Date:_____ Social Security #:_____ Phone #:_____
Address:_____
Employer:_____ Work Phone:_____
Employer Address:_____

Insurance Company:_____ Phone #:_____
Address:_____
ID #:_____ Group #:_____

Secondary Insurance

Policy Holder:_____ Relationship to patient:_____
Birth Date:_____ Social Security #:_____ Phone #:_____
Address:_____
Employer:_____ Work Phone:_____
Employer Address:_____

Insurance Company:_____ Phone #:_____
Address:_____
ID #:_____ Group #:_____

Insurance Authorization

I request that payment of authorized Insurance benefits for any services furnished to me, be made on my behalf to RiverCity EyeCare, Inc.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

_____ _____
☐ *Patient or* ☐ *Guardian Signature* *Date*

Acknowledgement of Receipt of Privacy Policies

I acknowledge that I received a copy of the Notice of Privacy Practices for this office.

_____ _____
☐ *Patient or* ☐ *Guardian Signature* *Date*