PATIENT INSURANCE INFORMATION

Please provide us with the following information and your insurance card. (WE WILL BE UNABLE TO FILE YOUR INSURANCE CLAIM WITHOUT A COPY OF YOUR INSURANCE CARD). All the blanks MUST be completed.

Name of Patient:_____DOB:_____
(please print the name of the patient as it appears on the insurance card.)

Name of Policy Holder:_____DOB of Policy Holder: _____
(please print the name of the policy holder as it appears on the insurance card.)

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Policy Holder's Employer: _____

Policy Holder's Address: _____

_____

Policy Holder's Social Security #: _____

Policy ID# : _____
(please write your ID# as it appears on your insurance card)

Name of Insurance Plan: _____

Group/Account # : _____

Please note that full payment for copays, overages, non-covered items, etc. is required at the time services are rendered. **Verification of eligibility and authorization numbers from your insurance company is not a guarantee of payment. Final determination of payment is made when said insurance company receives the actual claim.** Please remember that filing insurance is a courtesy and you are ultimately responsible for knowing what your insurance benefits are.

Assignment and release- (Permission to file your claim to your insurance company for you.)

I hereby authorize the provider to release any information required to process my insurance claim. I also authorize my insurance benefits to be paid directly to the doctor. I understand that I am fully and financially responsible for any charges my insurance company cannot or will not pay.

_____ _____

Patient's Signature (Parent/Guardian Signature if patient is a minor) Date

Ardmore Premier Eyecare takes pride in serving patients with the utmost care and satisfaction. While our company does provide you opportunities to apply vision care insurance to your services and materials, we cannot assume responsibility for your insurance policies. **Verification of benefits and authorizations received from your insurance company are not a guarantee of payment.** Final determination of your benefits is made when your insurance company receives your claim. Therefore, *the amount you will pay today is your estimated portion.* **In the event your insurance company cannot or will not comply to make payment for your services, you, the patient, are responsible**. Please sign the bottom line to ensure you, understand all payments required for your services are ***your*** responsibility and due at the time said services are rendered.

ATTENTION CONTACT LENS PATIENTS

If you are having a contact lens fitting today, please note the following: A contact lens fitting is *elective* and is, therefore, **not covered by your insurance company**. If you are using your contact lens allowance to purchase your contact lenses today, you may deduct the cost of your fitting from that allowance. If you do not purchase contact lenses today or if you are using your insurance to purchase your glasses, you are responsible for paying the contact lens fitting fee.

I understand that Ardmore Premier Eyecare will bill me for any items and/or services denied by my insurance company. I understand that I am personally and financially responsible for these charges and will not hold Vision Trends liable for my insurance policy.

_____ _____

(Patient's signature, parent's if minor is insured) (Date of service)