Illinois Valley Eye Care

Please give insurance card(s) to receptionist to copy

Patient's Name_____ Patient's Date of Birth_____

Primary Vision Insurance:_____

Member Name_____ Member's Date of Birth_____

Member Address_____City_____State_____Zip_____

Member ID#_____ Member Social Security #_____

Primary Medical Insurance:_____

Member Name_____ Member's Date of Birth_____

Member Address _____City_____State_____Zip_____

Member ID#_____ Member Social Security #_____

Supplement Insurance:_____

Member Name_____ Member's Date of Birth_____

Member Address_____City_____State_____Zip_____

Member ID#_____ Member Social Security #_____

I certify that the information given by me in applying for insurance and/or medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Eyesite Illinois Valley, LLC, on my behalf for any services and materials furnished. I authorize any holder of medical information about me to be release to the Center for Medicare and Medicaid Services and/or my insurance company and it's agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 on the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I also understand that any balance above and beyond what insurance will pay for, will be my responsibility to pay.

X_____ _____

LIFETIME PATIENT SIGNATURE **DATE**

WAIVER OF LIABILITY FOR REFRACTION

I have been informed that the charge being made for the refraction portion of the eye exam is a charge that is not covered by Medicare.

X_____ _____

SIGNATURE **DATE**