eyesite**ESO**ottawa

INSURANCE INFORMATION

Patient's Name ____Patient's Date of Birth____________

Primary Vision Insurance *if applicable*: **circle one** VSP EyeMed Spectera VCP Other_______

Member's Name _____________________________________Member's Date of Birth ____________

Member's ID # __________________________Member's Social Security #_______________________

Address of Member if different from Patient X____

Primary Medical Insurance:____

Member's Name _______________________________________Member's Date of Birth ___________

Member's ID # _______________________Member's Social Security #_________________________

Secondary Medical Insurance:____

Member's Name _______________________________________Member's Date of Birth ___________

Member's ID # _______________________Member's Social Security #_________________________

Insurance Waiver of Liability: I certify that the insurance information is true and correct. I authorize EyeSite as my agent in helping me obtain payment from my insurance and/or Medicare benefits. I authorize payment of these benefits directly to EyeSite Illinois Valley, LLC on my behalf for services and materials furnished. I authorize EyeSite to release medical information about me to my insurance company and /or Medicare and its agents needed to determine these benefits payable to related services.

I understand that any balance above and beyond what insurance covers, will be my responsibility.

I understand that in the event the charges are put towards deductible, I will be responsible for those charges.

X____ X______________________

Lifetime Patient or Member Signature Date

Medicare Only: 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____ X______________________

Lifetime Patient or Member Signature Date

Doctors: Kent Kunkel, OD Beth Kunkel OD Alex Uhlenhopp, OD