PRECISION EYE CARE AND OPTICAL

INSURANCE AUTHORIZATION FORM

Please Read the Information below related to insurance coverage:

For **routine vision coverage** verification and authorization coverage is required. If your insurance company is closed or unable to be reached (evening or weekend hours), you will be required to pay in full today, but we will gladly file any paperwork needed for your reimbursement.

If you have Medicare and your supplement does not cross over, you will be responsible for paying the 20% not covered by Medicare and the $25 refraction fee which is **not** covered, Medicare only pays for services related to **MEDICAL EYE PROBLEMS**, not routine vision.

Are you the primary policy holder? Yes or No

If yes, please skip to the signature line at the bottom.

If no, please list the **primary policy holder's name**: _____ **SS#** _____ **DOB**: _____

I: Authorization to bill insurance on behalf of patient:

I authorize Precision Eye Care & Optical to bill my insurance and authorize the insurance company to pay any benefits due to them. From this day forward, I authorize the use of this signature on any and all my insurance submissions by this office and permit the release of any information necessary for the processing of these claims.

II: Patient Responsibility:

If you do not have insurance, payment is expected at the time of service unless prior arrangements have been made with this office. We will file your primary insurance as a courtesy to you. I understand that I am liable for payment of any portion of my claim not paid by my insurance and further agree that the account balance is due in full, upon receipt of the statement. A $25.00 late charge will be added to overdue accounts. A $50.00 returned check fee will be added to all returned checks. You agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at the maximum rate of 33.5% of the amount due at the time your account is placed with a collection agency and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

I understand and agree with the information listed above:

Patient signature (or legal guardian if **under** 18): _____ Date: _____

Print Name (or legal guardian if **under** 18): _____ rev: 12/05/2018