PINNACLE EYE GROUP

Patient Financial Information Sheet

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient: _____ **DOB**_____

Name of Insured: _____ **DOB**_____

If No Insurance Card is Available please supply the Insurance Carrier and ID #
Name of Insurance Carrier: _____

ID#:_____ **Policy #:**_____

Insurance Card Copied: _____ Yes _____ No _____ No Card

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: _____

_____ _____
Signature of patient or parent if minor Date

HIPAA Privacy Practice acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature: _____ **Date:** _____