Patient Insurance Information

Name of Patient:_____ Who provides your insurance? ☐ Self ☐ Spouse ☐ Mother ☐ Father

Name of Person that Pays the Premium for your Insurance: _____

Their ADDRESS:_____ City_____ State _____ Zip Code_____

Their DATE of BIRTH _____ Their SOCIAL SECURITY # _____-_____-_____

Their EMPLOYER_____Occupation_____Work Phone_____

Vision Insurance (COMPANY NAME) _____ Card ID Number _____

Medical Insurance (COMPANY NAME) _____ Card ID Number _____

(All the above information is needed to process your insurance claim correctly)

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 **Sight $avers Family Eye Care, PLLC/ Dr. Richard P. Steinhauser,** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid services and its agents any information needed to determine these benefits payable to related services. If I have other insurance coverage (as indicated in item 9 of 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 this office/doctor to act as my agent, as above.

_____ _____

Lifetime Patient Signature Date