(PLEASE PRINT) Patient name_____

Vision Insurance

Name of Vision Insurance Plan_____

Name of Policy Holder_____ **DOB**____/____/____

Address_____ **City**_____ **State**___**Zip**_____

ID #_____ **SS #**_____

Patient Relationship to Policy Holder: Self - Spouse - Dependent - Other

Medical Insurance

Name of Medical Insurance Plan_____

Name of Policy Holder_____ **DOB**____/____/____

Address_____ **City**_____ **State**___**Zip**_____

ID #_____ **SS #**_____

Patient Relationship to Policy Holder: Self - Spouse - Dependent - Other

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. If verification for insurance coverage is not available upon visit, all professional fees will be charged at the time of service.

Please understand that financial responsibility for your account is yours, not your insurance company's. *Note to Medicare Patients: Medicare will not pay for refractive services or other services deemed not medically necessary.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to Bacho Family Eye Care LLC.

Signature_____ **Date**_____

PRIVACY POLICY ACKNOWLEDGMENT

Before we collect your information, we want to make sure that you are aware of our privacy policy. The policy explains why we collect your information and how it will be used. We have posted our policy in the office and have a copy available if you would like to take one and review it. Please sign below to verify that we have informed you of our privacy policy and have made a copy available to you.

Signature_____ **Date**_____

Name _____ **(Please Print)**