

INSURANCE WAIVER

Please take a few moments to fill out this form as completely as possible and sign where appropriate.

Patient Name _____ **DOB** _____ **Date** _____

RESPONSIBLE PARTY INFORMATION

Responsible Party _____ **Relationship** _____ **DOB** _____

Social Security Number _____ - _____ - _____ **Driver's License #** _____

INSURANCE INFORMATION

Vision Insurance Co. _____ **Policy #** _____

Group # _____ **Subscriber Name** _____ **DOB** _____

Subscriber Social Security Number _____ - _____ - _____ **Relationship** _____

Primary Medical Insurance Co. _____ **Policy #** _____

Group # _____ **Subscriber Name** _____ **DOB** _____

Subscriber Social Security Number _____ - _____ - _____ **Relationship** _____

Secondary Medical Insurance Co. _____ **Policy #** _____

Group # _____ **Subscriber Name** _____ **DOB** _____

Subscriber Social Security Number _____ - _____ - _____ **Relationship** _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage and authorize benefits be made payable on my behalf to South East Eye Specialists for services rendered to me. I authorize the use of my signature on all insurance submissions.

South East Eye Specialists may use my health care information and may disclose such information to the above-named insurance companies and their agents for the purpose of obtaining payment for and determining insurance benefits payable for related services.

Although South East Eye Specialists has verified my eligibility through the information provided, I understand that this is not a guarantee of payment by my insurance company. In the event that any services and/or materials are denied payment, or I have coverage through another third party insurance that South East Eye Specialists does not accept, I will be responsible for payment of the denied charges.

Patient or Responsible Party's Signature _____ **Date** _____