INSURANCE INFORMATION

PLEASE NOTE THAT **VISION CENTER IS NOT RESPONSIBLE** FOR KNOWING YOUR INSURANCE POLICY, CO-PAYS, AND/OR REFERRAL AUTHORIZATION GUIDELINES.

DO YOU HAVE INSURANCE FOR MEDICAL AND/OR VISION COVERAGE? **YES** ____ **NO** ____
IF YES, PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST TO BE COPIED.

AUTHORIZATIONS:

1. I hereby authorize comprehensive eye examinations, and
2. I am responsible for any co-pays or portions of fees my insurance does not cover. In addition, I agree to release medical information for processing an insurance claim, and
3. I understand that several insurances do not pay for the refraction portion of the medical examination, and
4. I authorize payment of the medical benefits to Vision Center for services rendered.

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Vision Center for any services or equipment provided to me by Vision Center.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services or equipment to Vision Center, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will only be sent to the Health Care Financing Administration, my insurance company or any other medical entity, if requested. The original authorization will be kept on file by Vision Center.

I understand that I am financially responsible to Vision Center for any charges not covered by health care benefits. It is my responsibility to notify Vision Center of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until Vision Center receives the claim. I am responsible for the entire bill or balance of the bill as determined by Vision Center and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of Vision Center's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPPA) to ensure that I have been made aware of my privacy rights.

Signature of Insured or Parent/Guardian _____ Date: _____

Printed Name if Parent or Guardian_____

St. Croix Vision Center Inc. (dba Vision Center)

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