

INSURANCE INFORMATION

Beaverton Vision World's first and foremost priority is to provide excellent eye care for every one of our patients. We will gladly bill the primary insurance carrier, and if a referral is required try to obtain one, as a courtesy to our patients, however, it is ultimately the primary policy holder's responsibility to make sure that payment is received in a timely manner and that all referrals are approved by the primary care physician. It is also the primary policyholder's responsibility to know their insurance carrier and individual policy. As another courtesy to our patients we will verify insurance benefits but this does not guarantee payment and Beaverton Vision World will not be held responsible. Any and all unpaid insurance balances are transferred to the patient after 90 days.

Insurance Company _____

Member Name _____

Member ID # _____ Group # _____

Policy Holder's SS# _____ - _____ - _____ DOB _____ - _____ - _____

Employer Name _____

If minor, full time student? Yes/No

AUTHORIZATION

*I certify that I have read and understand the information on this sheet to the best of my knowledge and have answered all questions honestly and accurately. I authorize **Beaverton Vision World** to release any information including the diagnosis and the records of any treatment or examination rendered to me or any of my dependents during the period of such eyecare to third party payees and/or health care practitioners. I authorize and request my insurance company to pay this office directly and in the event that the insurance company remits direct payment to myself, I agree to be responsible for all charges of the services rendered. I agree to pay for any balances transferred to my account due to a lack of referral and will not hold Beaverton Vision World responsible for provider adjustments or write-offs in such event. I also understand that my insurance carrier may pay less than the actual bill for services, of which I agree to be responsible for any unpaid balances for myself and/or dependents.*

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Patient Signature (or Parent signature if minor)

Date _____