Carolina LLC
FAMILY EYECARE
YOUR CLEAR CHOICE FOR EYE CARE

Insurance Information

List name of vision insurance:_____
ID#:_____
List name of health insurance:_____
ID#:_____
Policyholder's First and Last name:_____
Policyholder's D.O.B:_____ Relation:_____

I hereby authorize Carolina Family Eyecare to release any information to process this claim. I also authorize my insurance benefits be paid directly to the physician. I acknowledge that all information above is complete and correct. I understand that I am financially responsible for any services not covered by insurance.

_____ _____
Sign Date

PLEASE READ:

We make every effort to verify insurance coverage before the patient is seen. In our experience, phone verification does NOT guarantee reimbursement. In such cases we will file and re-file the claim. If the claim is denied after the second attempt in filing a bill will be sent. At that point, you may contact your insurance carrier if you feel that the claim was denied in error.

I acknowledge that I received a copy of the Notice of Privacy Practices, HIPAA.

_____ _____
Sign Date

Please list names of anyone we may speak with regarding your records and/or account:

Name: _____ Relation:_____
Name: _____ Relation:_____
Name: _____ Relation:_____

_____ _____
Sign Date