BAKER EYE CARE

Financial Information

Patient name: _____ DOB: _____

Name of insured:_____ DOB:_____

Insurance carrier: _____

ID#:_____ Policy/Medicare #: _____

Authorization:

___ I authorize use of this form on all my insurance submissions.

___ I authorize release of information to all my insurance carriers.

___ I understand that I am responsible for my bill.

___ I authorize my doctor to act as my agent in obtaining payment from my insurance carriers.

___ I authorize payment directly to my doctor.

___I understand my insurance may pay less than the actual price for services rendered. I understand my responsibility in payment of all services rendered at Baker Eye Care.

___I permit a copy of this authorization to be use in place of the original.

___I acknowledge the Baker Eye Care Notice of Privacy Practices was made available to me.

_____ _____

Signature of patient or parent Date