LAKESIDE
FAMILY EYE CARE

Insurance and Financial Consent

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient: _____ DOB: _____

Name of Policy Holder: _____ DOB: _____

Insurance Card Copied: ☐ Yes ☐ No ☐ No Card

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me including any Telehealth visits.

I understand my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and records of any treatment or examinations rendered to me or my child to: _____

Name of family member, guardian, etc or NA)

_____ _____

Signature of patient or parent if minor Date

HIPAA Privacy Practice Acknowledgement

I received or was offered and declined a notice of privacy practices.

Signature: _____ Date: _____