INSURANCE INFORMATION

Tomoka Eye Associates participates with Medicare and many other insurance networks. It is ultimately the patient's responsibility to ensure network participation with your insurance company. ***Tomoka Eye Associates cannot assume responsibility for network participation.*** *Please provide a photo ID and insurance cards to receptionist for copying.*

Patient Name: _____
First Middle Last

Primary Insurance Information:

Insurance Company Name: _____

Policy Number: _____Group# _____

Policy Holder (if other than patient): _____

Date of Birth: _____/_____/_____ Relationship to patient: _____

Secondary Insurance Information:

Insurance Company Name: _____

Policy Number: _____Group# _____

Policy Holder (if other than patient): _____

Date of Birth: _____/_____/_____ Relationship to patient: _____

Insurance Authorization:

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or other insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare or other insurance for payment to me.

We file claims to Medicare and most insurance plans. *We do not file any Vision Plans.* As a courtesy, we will file secondary insurances. If payment is not received within ninety days, **you will be billed.** If incorrect insurance information is provided to us, we will be unable to file a claim after 90 days from the date of service. All professional services are the patients' responsibility regardless of insurance coverage. You are expected to pay for any DEDUCTIBLES, CO-PAYMENTS and NON-COVERED SERVICES, **at the time of service.** We accept CASH, CHECKS, VISA, MASTERCARD and DISCOVER.

Patient Signature: _____Date: _____
Relationship if other than patient _____Reason_____

REV. 3/09