PATIENT'S LAST NAME	FIRST NAME	MIDDLE	DATE OF BIRTH	SOCIAL SECURITY NUMBER (REQUIRED above age of 18)

OFFICE USE ONLY

BENEFITS CHECKED BY:
VERIFICATION DATE:

☐INTERNET ☐PHONE/FAX
REPRESENTATIVES NAME:

REF/AUTH #

☐VISION ☐MEDICAL

☐IN NETWORK
☐OUT NETWORK
☐DISCOUNT ONLY

INSURANCE INFORMATION-POLICY HOLDERS INFORMATION

POLICY/SUBSCRIBERS'S ID #	GROUP ID #	RELATIONSHIP TO INSURED ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

INSURED'S LAST NAME	FIRST NAME	MIDDLE	DATE OF BIRTH

INSURED'S ADDRESS ☐ADDRESS SAME AS PATIENT CITY STATE ZIP

SOCIAL SECURITY NUMBER	INSURED'S PHONE NUMBER	EMPLOYER

MEDICAL BENEFITS: ☐ PRIMARY ☐ SECONDARY_____

Specialist Office Co-Pay:_____ Coinsurance Coverage: / Referral Required: Y N

Deductible:_____ Deductible Met: YES NO Amount of Deductible Met: _____.____

ROUTINE VISION BENEFITS: ☐Eligible ☐NOT Eligible Date of Eligibility:_____ Last date of Service:_____

Co-Pay:_____ ☐Routine Not Covered PER: ☐Calender Year ☐12 Months Rolling Period ☐24 Months/2 Years

Maximum Benefit:_____ Coinsurance: / Optos:_____ Visual Filed:_____

Deductible:_____ Deductible Applicable: YES NO Deductible Met: YES NO Amount of Deductible Met:_____

CONTACT LENS EVALUATION: STANDARD_____ PREMIUM_____ ☐ NOT COVERED

CONTACT LENS BENEFITS: ☐Eligible ☐NOT Eligible Date of Eligibility:_____ Last date of Service:_____

Co-Pay:_____ PER: ☐Calender Year ☐12 Months Rolling Period ☐24 Months/2 Years

Maximum Benefit:_____ Coinsurance: / MEDICAL NECESSITY CTL COVERAGE:_____

Our Financial Policy Regarding Insurance

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We file insurance as a courtesy to our patients; however we do require you to pay your expected portion of the bill when services are rendered. This does include non-covered services, co-pays, deductibles, eye refractions, and contact lens evaluation fees. Benefits are based on the information received from your insurance provider on the day of service and does not reflect claims recently submitted. Final determination of your claim is based on when your claim is received and can change due to contract changes and policy cancellations. If your insurance has not responded in 60 days after filing the entire balance will be your responsibility. We consider you the responsible party. We will bill 3 times and after the third and final billing, the balance will then be turned over for collections with an added 30% collection fee to the remaining balance along with an additional 2% interest charge left on any unpaid balance after 30 days.

I hereby request that the payment of Medicare, Tenn care, Medigap, or other insurance benefits be made to *James L. Ducklo, O.D. and Associates* for any services. I authorize any hold of medical information about me to release to the Center for Medicaid/Medicare Center (CMS), or to my insurer, any information needed to determine these benefits.

Thank you for understanding our Financial Policy. Please let me know of any concerns or questions.

I have read the Financial Policy. I understand and agree to this Financial Policy

Signature of Patient or Responsible Party Today's Date