PEDIATRIC Ophthalmology CONSULTANTS, LLC.

INSURANCE INFORMATION

Patient's Name: _____ **Group#** _____

Primary Insurance: _____ **Individual # / Policy #** _____

Subscriber: _____ **Subcriber's Social Security #** _____

Relationship to patient: _____ **Subcriber's date of birth:** ____/____/____

Secondary Insurance: _____ **Individual # / Policy #** _____

Subscriber: _____ **Subcriber's Social Security #** _____

Relationship to patient: _____ **Subcriber's date of birth:** ____/____/____

I authorize the release of any medical information needed to process all claims and I authorize the release of payment for medical benefits to my physician.

Patient or Parent Signature: _____ **Date:** _____/_____/_____

I accept that I am fully responsible for any co-pays, deductibles or items not covered by my insurance. I am also aware that I may be charged a collection fee of $25.00 if I do not pay Pediatric Ophthalmology Consults for these charges in a timely matter.

Patient or Parent Signature: _____ **Date:** _____/_____/_____

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