

INSURANCE INFORMATION

Patient's Name: _____ Date of Birth: ___/___/___
Social Security Number: _____ - _____ - _____

VISION INSURANCE

Insurance Provider: _____
Member ID #: _____ Group #: _____
Insured Name: _____ Insured Birth Date: ___/___/___
Insured Employer: _____ Relation to Insured: Self Spouse Child

PRIMARY MEDICAL INSURANCE

Insurance Provider: _____
Member ID #: _____ Group #: _____
Insured Name: _____ Insured Birth Date: ___/___/___
Insured Employer: _____ Relation to Insured: Self Spouse Child

SECONDARY MEDICAL INSURANCE (IF APPLICABLE)

Insurance Provider: _____
Member ID #: _____ Group #: _____
Insured Name: _____ Insured Birth Date: ___/___/___
Insured Employer: _____ Relation to Insured: Self Spouse Child

Was the HIPAA – Notice of Privacy Practices form made available to you? _____ (Please initial)

(Eye patients)

Head to Toe Healthcare PLC – Advanced Eye and Foot Care provides comprehensive routine and medical eye exams. This includes not only vision correction but also screenings for other ocular conditions and systemic diseases. During your vision examination, should a medical condition arise, be advised that it is not covered under your routine eye benefits through your vision insurance plan. Medical exams are billed through your Major Medical Carrier and are subjected to their specific Co-pays, Deductibles, Co-insurance and will be due at the time of service. In the event that I do not wish the Doctor to proceed with a medical examination, I understand that it is my responsibility to immediately inform the doctor as she/ he can refer me to the appropriate specialty doctor.

(Eye and foot patients)

I hereby authorize any payment for my services today to **Head to Toe Healthcare PLC – Advanced Eye and Foot Care**. I understand that if my employer, insurance carrier or plan sponsor refuses payment to any portion of my claim, I am financially liable and responsible for the outstanding balance/ charges on my account. Any unpaid balance on my account or my family's account is subjected to 1.5% per month interest rate or 18% per year. Should there be any legal action filed, I am responsible for the collection fees, attorney fees, filing fees, and any cost the court determines. Obtained authorization does not guarantee payment and any denied services will be billed to the patient.

Patient/ Guardian Signature: _____ Date: ___/___/___