SHREYA PATEL OD PC
Insurance Information, Financial Policy and Acknowledgment of Privacy Practice

PRIVATE PAY PATIENTS AND NON-PARTICIPATING WITH PATIENT'S INSURANCE

If you are uninsured or we do not participate with your insurance you are individually responsible to pay all charges in full at the time of service. We are happy to provide you with an itemized bill at your request.

PARTICIPATING INSURANCE

It is important for you to understand that your insurance contract is an agreement between you and your insurance company. We are happy to file claims to your insurance, when applicable, as a courtesy to you. Although we attempt to verify eligibility before your visit, insurance companies will not guarantee payment, coverage, or benefits and so we do not know what will or will not actually be paid by them until we receive the explanation of benefits that usually accompanies insurance payment or denial. We require that copayments and/or deductibles be paid at the time of service. We will send you a bill for any uncovered charges after insurance has responded to our claim.

VISION INSURANCE

☐No Insurance

Insurance Company______________________________________ Policy Holder's Employer___________________________

ID number____ Group number____________________________________

Name of Policy Holder____ Policy Holder's Birthdate _________________

Relationship to Patient____________________________ Policy Holder's Social Security #____________________________

Address if different than patient____Phone#______________________

MEDICAL INSURANCE

☐No Insurance

Insurance Company____________________________________Policy Holder's Employer____________________________

ID number______________________________________ Group number____

Name of Policy Holder_______________________________________ Policy Holder's Birthdate _______________________

Relationship to Patient____________________________ Policy Holder's Social Security #____________________________

ADDITIONAL INSURANCE PLANS

Insurance Company____________________________________ Policy Holder's Employer_____________________________

ID number______________________________________ Group number____

Name of Policy Holder_______________________________________ Policy Holder's Birthdate

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Relationship to Patient____________________________ Policy Holder's Social Security #_____________________________

Address if different than patient____Phone#______________________

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I certify that I/my dependent have/has vision and/or medical insurance coverage. The information given by me in applying for insurance payment is true and correct. I assign all insurance benefits for services rendered, otherwise payable to me, directly to Shreya Patel OD PC. I understand that I am financially responsible for all fees and charges whether or not paid by the insurance company. I hereby authorize Shreya Patel OD PC to release any information necessary to secure payment of benefits. I authorize the use of a photocopy of this signature on all insurance submissions for the period of my lifetime.

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Signature of Patient or Authorized Date

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I was given the opportunity to review a copy of Shreya Patel OD PC's Notice of Privacy Practice.

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Signature of Patient or Authorized Date

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