# Patient Insurance Information

Patient name ________________________________ Parent or Guardian name (if minor)

Printed ______________________________ Signature ___________________________

Patient address ________________________________

________________________________

Patient telephone ____________________ Patient email address ______________________

(This office DOES NOT share your information or send "junk" emails)

**Vision** Insurance Carrier ______________________________________

Address and phone ______________________________________

______________________________________

Member Name ______________________________________

Employer ______________________________________

Insurance ID number __________________ Group number __________

## NOTICE TO INSURANCE PATIENTS

**I AM REPSONSIBLE FOR MY TOTAL BALANCE INCURRED IF ANY OF THE FOLLOWING OCCURS:**

- The treatment or charges incurred goes over my yearly maximum.
- My insurance company denies any treatment or charges.
- I am not eligible for insurance under the plan in which I have given the information for.
- I receive my insurance check and do not send it to your office.

- **I hereby authorize payment directly to Erie Optical. I understand I am financially responsible for any charges not covered. I understand Erie Optical will submit a claim for my services rendered today, however it is my responsibility to ensure my claim is paid in a timely manner. If my insurance company has not paid this claim within sixty (60) days I will be responsible for the balance and will be reimbursed when the insurance company pays the claim.**

  Patient Signature __________________________________________