FOREST PLACE OPTICAL

Billing & Insurance

HIPAA compliance

Billing and Insurance Information

Name of Responsible Party:____
Relationship to Patient____
SS#____

If you are not using Vision Insurance, please check this box and skip this section. ☐

Please note that your Vision Insurance provider may be different from your Health Insurance Provider.

Primary Vision Insurance Co.:____
Employer Providing Insurance:____
Subscriber Name:____
Date of Birth:____
SS#____

Secondary Vision Insurance Co.:____
Employer Providing Insurance:____
Subscriber Name:____
Date of Birth:____
SS#____

Assignment and Release

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance.
I hereby authorize the release of any and all informaiton needed to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature____
Date____

HIPAA Notice of Privacy Practice Acknowledgement of Receipt

A new federal law (HIPAA) requires us to document our policies regarding the privacy of your personal and medical information. This information is available t o you in our Notice of Privacy Practices. You may take a copy of this notice for your recoreds. Please sign below to acknowledge your receipt of this information.

Signature____

HIPAA Compliant

Copyright 2015 Forest Place Optical