FOREST PLACE OPTICAL

# Billing and Insurance Information

HIPAA compliance

Name of Responsible Party:_____
Relationship to Patient_____
ID#_____

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:_____
ID#_____

Secondary Vision Insurance Co.:_____
Employer Providing Insurance:_____
Subscriber Name:_____
Date of Birth:_____
ID#_____

## 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 information 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 Acknowledgment of Receipt

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

Signature_____

HIPAA COMPLIANT