Plaza Eye Clinic, PA dba Cross Eye Centers
Insurance Claims filing and Information Release Authorization

***PLEASE GIVE THE RECEPTIONIST YOUR CURRENT MEDICAL INSURANCE CARD (S) SO WE MAY KEEP A COPY ON FILE*.**

Primary Insurance Plan Name:_____ Effective Date:_____

Plan Holder Name: _____ Relationship: O Spouse O Child O Other_____

Plan Holder's DOB: _____ Plan ID# :_____ Group Number:_____

Secondary Insurance Plan Name:_____ Effective Date:_____

Plan Holder Name: _____ Relationship: O Spouse O Child O Other_____

Plan Holder's DOB: _____ Plan ID #:_____ Group Number:_____

***IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT?*** O***YES*** O***NO***
***IF YES, PLEASE NOTIFY THE RECEPTIONIST.***

I hereby authorize Plaza Eye Clinic, PA dba Cross Eye Centers to file claims to my insurance company (s) for services rendered to me by Plaza Eye Clinic, PA dba Cross Eye Centers. I certify that the information I have reported with regard to my insurance company is correct. I understand that I am responsible to notify Plaza Eye Clinic, PA dba Cross Eye Centers if my insurance changes, benefits are terminated or if the coverage I have reported is incorrect, I understand and agree that it is my responsibility to understand my benefits of my insurance plan and that failing to do so may result in a lesser payment or no payment at all from my insurance carrier(s). I understand and agree that I am ultimately responsible for payment in full for all services that I have received for Plaza Eye Clinic, PA dba Cross Eye Centers. I understand and agree that any and all referral, documentation and/or information, if required, is MY responsibility to obtain and provide to Plaza Eye Clinic PA, dba Cross Eye Centers.

I authorize Plaza Eye Clinic, PA dba Cross Eye Centers to release any information, including medical information for claims to my insurance company(s) or reimbursement agency, or in the case of Medicare Part B benefits to the Social Security Administration, in order to determine benefits to which I may be entitled. I hereby authorize payment be made directly to Plaza eye Clinic, PA, dba Cross Eye Centers, realizing that I am responsible to pay any deductible, copay or non-covered service as determined by my insurance company. In the event the account must be placed with an attorney or collection agency to obtain payment from me, I shall be responsible for all attorney and collection fees incurred.

I may revoke this authorization at any time in writing. In the case of Medicare Coverage, the Social Security Administration may revoke this authorization at any time in writing.

I have read, understand and agree to the terms and conditions above.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Witness Date

**FOR PATIENTS WHO DO NOT HAVE INSURANCE, INSURANCE CARDS, AND/OR REFERRALS IF REQUIRED**

I acknowledge that I did not bring a referral as required by my insurance company and/or do not have insurance or insurance cards. I am electing to pay for the services rendered since I do not have a referral or insurance or insurance cards.

_____ _____
Signature Date