

# Clear Image Eyecare, LLC Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information. All information will be confidential. Please Print.

Date \_\_\_\_\_ Legal Name: Mr. Mrs. Ms. Dr. \_\_\_\_\_  
(Please Circle) (First - - Middle Initial - - Last Name)

Name You Wish to be Called \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Male / Female Social Security Number \_\_\_\_\_  
(Please Circle)

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ or Cellular/Mobile Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Referred By \_\_\_\_\_

## **Responsible Party (If above patient is under 18 years of age)**

Name of person responsible for this account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## **Insurance Information-Primary**

Insurance Company \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Do you have additional insurance – **Secondary?** Yes / No If Yes, Name \_\_\_\_\_  
(Please Circle)

## **Insurance Office Submission**

The following information pertaining to my medical/vision services/materials provided by Clear Image Eyecare, LLC has fully been explained to me.

1. The patient/guarantor is ultimately responsible for any portion or the entire bill not covered by the insurance company or vision/medical plan for any reason.
2. I understand that some services or materials are non-covered, but agree to pay the additional charges.
3. I understand that insurance quotes on eligibility or coverage amounts (full partial, or non-covered) cannot be guaranteed.
4. I do not hold Clear Image Eyecare, LLC responsible in any way for denial of payment (full or partial) on any claims submitted.
5. I understand that the guarantor is responsible for any unpaid portion of the bill, and agree to pay the balance in full.

I agree to all the stated terms.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

I authorize the release of any information pertinent to my case to any third party company, adjuster, physician, or attorney involved in this case.

\_\_\_\_\_  
Responsible Party Signature Relationship Date