

## INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Policy Holder Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Group Number \_\_\_\_\_ Date of Birth of Policy Holder \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy Holder Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Group Number \_\_\_\_\_ Date of Birth of Policy Holder \_\_\_\_\_

### Medicare Patients:

*I understand that I am responsible for paying the 20% co-insurance not covered by Medicare as well as any Medicare Non-Covered services. I understand that I am also responsible for any deductible not covered by my insurance. In the event that Medicare claims not to be my primary insurer, I am aware that I shall be responsible for all bills in their entirety.*

Signature: \_\_\_\_\_

### All Patients:

*Part of your examination may include a procedure called "refraction". This is a test to diagnose diseases of the eye and to determine your best possible vision. Unfortunately, this service is not covered by Medicare and most insurance policies. Payment of \$75 for this service is the responsibility of the patient.*

## INSURANCE PAYMENT ORDER

*I hereby assign to Lisa Park, MD all payments for medical services rendered to myself or to my dependants under the terms of my insurance policy. Payment is authorized upon receipt of an itemized statement for services rendered to me. I also authorize release of medical information by Lisa Park, MD to determine payable benefits. I understand that I am financially responsible for any charge incurred whether or not paid for by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.*

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date