Havasu Eye Center Patient Insurance Release

There are two types of health insurance that will help pay for your eye care services and products. Havasu Eye Center accepts both types of insurance plans:

Vision Insurance (such as VSP, Eyemed)	Medical Insurance (such as Medicare, BC/BS)
- Routine vision exam for eyeglasses and/or contact lenses - Basic screening for eye disease - NO coverage for diagnosis, management and/or treatment of eye diseases	- Diagnosis, management, and/or treatment of eye diseases - Systemic health problems that affect eye health

You may have both types of insurance plans, and it may be necessary for us to bill some services to one plan and other services to the other. We will try to coordinate your benefits to minimize your out-of-pocket expense. By signing below, I authorize Havasu Eye Center to bill my insurance for products or services rendered. I understand and agree that I am responsible to ensure that Havasu Eye Center is contracted with my insurance plan before services are performed, and that I am ultimately responsible to pay for all products and services from Havasu Eye Center.

Medicare does not pay for the refractive service to determine your prescription for glasses and/or contact lenses. The fee for this service is $32 and is the patient's responsibility.

Signature:	Date:

Please check all boxes that apply and provide your insurance information:

- **I have Vision Insurance (glasses and/or contact lens insurance benefits)**

  Vision Insurance Name: ____________________
  I.D. #: ____________________
  Main Member Name: ____________________
  Main Member D.O.B: ____________________

- **I have a Medicare Replacement Plan**

- **I have Medical Insurance (Medicare, BC/BS, etc.)**

  Primary Medical Insurance: ____________________
  I.D. #: ____________________
  Main Member Name: ____________________
  Main Member D.O.B: ____________________
  Secondary Medical Insurance: ____________________
  I.D. #: ____________________
  Main Member Name: ____________________
  Main Member D.O.B: ____________________

For future use, if no changes:	
Signature:	Date:
Signature:	Date: