Insurance/Financial Responsibility Agreement

Patient Name:____

Insurance #1

Insurance Provider:____

Subscriber Name:______________________________**Date of Birth:**____________

Insurance #2

Insurance Provider:____

Subscriber Name:______________________________**Date of Birth:**____________

Name of Primary Care Physician:____

I authorize:

- The release of medical information to all of my insurance companies
- Payment made directly to Jordan Family Eyecare
- Photocopies of this authorization to be used in place of the original
- Jordan Family Eyecare to act as my agent to aid in obtaining insurance payments

I understand and agree:

- I acknowledge that I am responsible for knowing my individual eyecare and eyewear insurance benefits and eligibility, not Jordan Family Eyecare. Please note this includes obtaining referrals, knowledge of eligibility dates of service, and eyeglass/contact lens benefits.
- Jordan Family Eyecare is **not currently contracted with any vision service plans including, but not limited to, VSP or Eyemed.** An itemized receipt will be supplied for me to submit for reimbursement from my insurance company upon request.
- Any appointment that is cancelled or broken without 24-hour notice may be subject to a fee.

In the event that my insurance company does not cover any claim, I understand that I am responsible for payment of services and materials rendered.

By signing this form, I agree to all of the terms listed above.

Signature: ____ Date:_______________

Relating to Minors:

Signature of Responsible Party:_________________________Date:_______________