

PRIMARY INSURANCE INFORMATION

CAREHOLDER NAME _____ BIRTHDATE _____

SOCIAL SECURITY# _____ RELATIONSHIP TO PATIENT _____

NAME OF INSURANCE _____ PHONE# _____

I AUTHORIZE LOOKING GLASS EYE CENTER TO LEAVE A MESSAGE ON MY ANSWERING
MACHINE: YES NO

I AUTHORIZE LOOKING GLASS EYE CENTER TO LEAVE APPOINTMENT/MEDICAL INFORMATION
WITH SPOUSE FAMILY MEMBER OR POWER OF ATTORNEY: YES(LIST NAMES BELOW) NO

I AUTHORIZE LOOKING GLASS EYE CENTER TO RELEASE ANY INFORMATION TO AN INSURANCE COMPANY THAT MAY BE NEEDED TO PROCESS AN INSURANCE CLAIM FOR MYSELF OR MY DEPENDENT. I ASSIGN ANY PAYABLE BENEFITS TO LOOKING GLASS EYE CENTER. WITH OR WITHOUT INSURANCE, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED WHILE UNDER THE CARE OF LOOKING GLASS EYE CENTER.

SIGNATURE _____ DATE _____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING A WRITTEN NOTIFICATION TO LOOKING GLASS EYE CENTER. I UNDERSTAND THAT THE REVOCATION IS NOT EFFECTIVE IN CASES WHERE THE INFORMATION HAS ALREADY BEEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED AS DESCRIBED IN THIS DOCUMENT. I CAN DO THIS BY WRITTEN NOTIFICATION TO LOOKING GLASS EYE CENTER. I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

SIGNATURE _____ DATE _____