Family Eyecare of Roswell

Maurice E. Zadeh, Optometrist & Associates

Insurance Billing Information

- This form is for finanical obligation purposes. All fields MUST be completed in order to file a claim on your behalf.
- Failure to provide the following information will result in self payment of your office visit today.
- Presentation of your Insurance Cards and a valid Driver's License, or valid photo ID Card, are required at your visit.
- If you are not using insurance today, the "Primary Insurance" section must still be completed and a valid Driver's License or valid photo ID Card must be presented.

Patient & Primary Insurance Information

Patient: _____ (Last / First / MI) Gender: Male | Female (circle one)

DOB: _____ (Month / Day / Year) SSN: _____ (Full SSN) Email: _____

Primary: _____ (Last / First / MI) Gender: Male | Female (circle one)

DOB: _____ (Month / Day / Year) SSN: _____ (Full SSN) Email: _____

Address: _____ (Street Number & Name) Employer: _____

_____ (City / State / Zip Code) Relationship to Patient: Self / Spouse / Parent (Circle One) Other:

Vision Plan Name: _____ ID# _____ Phone # _____

Second Vision Plan: _____ ID# _____ Phone # _____

Medical Plan Name: _____ ID# _____ Phone # _____

Secondary Medical: _____ ID# _____ Phone # _____

**** The insurance information that you provide on the day of service will be used to file your insurance claim(s).**

- If you would like a specific plan to be utilized for your visit, you must indicate which plan before you check out that day.
- All insurance claims are processed on the date of service, it is vital that we have the correct insurance information on file. If you request to have your office visit resubmitted or canceled and/or filed to a different insurance carrier after services have been rendered, **there will be a $50 fee for each claim processed.**

I am authorizing that the information I provided on this form is current and correct. I understand that any services provided to me that are not paid by my insurance carrier are my, or the guarantor's, finanical responsibility.

_____ Print (Patient Name)

_____ Print (Guarantor Name)

* Guarantor is the person responsible for account balances.

_____ Patient or Guarantor's Signature

_____ Today's Date