Family Eyecare of Roswell

Maurice E. Zadeh, Optometrist & Associates

Insurance & Billing Information

- This form is for financial 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: (required fields)

Patient: ______________________________ Gender: Male | Female

Last First MI (circle one)

DOB: ______________ SSN: ______________ Relationship to Insured: Self / Spouse / Child

Month / Day / Year Full SSN (Circle One) Other:

**** Please note: The "Primary Insurance Policy Holder" is considered the Guarantor on this patient's account.**

(The Guarantor is the person who will be held financially responsible for all balaces on this account.)

Primary: ______________________________ Gender: Male | Female

Last First MI (circle one)

Address: ______________________________ DOB: ______________

Street Number & Name Month / Day / Year

______________________________ SSN: ______________

City State Zip Full SSN

Vision Plan:	ID#	Phone #
Vision Plan (additional):	ID#	Phone #
Medical Plan (Primary):	ID#	Phone #
Medical Plan (Secondary):	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 claim resubmitted, canceled and/or filed to a different insurance carrier after the claim has been submitted, **there will be a $50 fee for each reprocessed claim.**

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, financial responsibility.

Print (Patient Name) Print (Guarantor Name)

Patient or Guarantor's Signature Today's Date