ROTHBAUM
EYE + VISION

PATIENT INSURANCE

(PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS TO FRONT DESK STAFF)

PRIMARY INSURANCE

INSURANCE COMPANY: _____

MEMBER ID: _____ GROUP ID: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

MEMBER ID: _____ GROUP ID: _____

VISION INSURANCE

COMPANY: _____

MEMBER ID: _____ GROUP ID: _____

Financial Policy and Signature on File

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to MICHAEL A ROTHBAUM MD LLC

I understand that I am financially responsible for all services rendered and for the following reasons:
1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company *(This applies to present and future visits).*

Patient or Responsible Party Signature_____Date_____

IF INFORMATION PROVIDED IS NOT ACCURATE AND CURRENT, WE WILL BE UNABLE TO PROCESS YOUR INSURANCE CLAIM. ANY OUTSTANDING CHARGES WILL BE YOUR RESPONSIBILITY.