Welcome

Insurance Information

We would like to make a copy of your insurance card and drivers license. Thank you.

Name of Insured _____ Relationship to Patient _____

Birth Date _____/_____/_____ Social Security # _____-_____-_____

Name of Employer _____ Date Employed _____/_____/_____

Work Phone ( ) _____-_____ How much is your medical copay? ____

Financial Policy and Authorization

To assist you in your financial obligations, we offer the following payment options. **We accept cash, check, some insurance, and credit cards.** Payment is due at the time of service.

For those patients with insurance, please inquire as to our acceptance at the current time of your company. Those we do not currently accept, we will collect payment today and file a claim for your reimbursement as your policy allows.

I authorize Dr. Davis to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third part payers and/or health practitioners. I authorized and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Agreement to pay: The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

_____

Signature of Patient / Guardian Date