Muirfield Eye Care

John F. Fanning, O.D.
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Muirfield Eye Care Center has the ability to file both medical and vision claims. We ask for you to provide us with the information below. Please provide any medical and/or vision cards you have to our staff so they may keep a copy on file with your records

Is there a **Vision Care Plan**? ____ Yes ____ No Name of plan: _____

ID#: _____ Primary Member: _____

Insured's Date of Birth: _____

Relationship to Policy Holder: ____Self ____Spouse ____Domestic Partner ____Child ____ Other

Medical Insurance Plan? ____ Yes ____ No Name of plan: _____

ID#: _____ Primary Member: _____

Insured's Date of Birth: _____

Relationship to Policy Holder: ____Self ____Spouse ____Domestic Partner ____Child ____ Other

Is there a **Secondary Medical Insurance Plan**? ____ Yes ____ No Name of plan:_____

ID#: _____ Primary Member: _____

Insured's Date of Birth: _____

Relationship to Policy Holder: ____Self ____Spouse ____Domestic Partner ____Child ____ Other

Individuals with whom we may share medical information (spouse, children, parents, caregivers, etc)

Name: _____ Phone: _____ Relationship:_____

Name: _____ Phone: _____ Relationship:_____

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Insurance coverage and terms are the patient's responsiblilty. Muirfield Eye Care Center tries to authorize each patient's vision insurance prior to their appointment. We do attempt to notify you in advance if we forsee any issues with your insurance. Please remember, your insurance contract is between you and the insurance carrier. It is possible that insurance may cover only part of the charges. If we do not accept direct payment from your insurance plan, you will be billed up-front and provided with a paid receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with any question on your claims.
Your signature below signifies you undestand this statement, and give the office of Muirfield Eye Care Center permission to authorize and file insurance claims on your behalf.

_____	_____	_____
Signature of Patient, parent, Guardian or Representative	Print Name	Date

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