Looking Out Vision, P.C. *Comprehensive and Compassionate Eyecare*
124 E. Jefferson St. – Morris, IL 60450 – 815-942-1951 – (Fax) 815-942-1958

Insurance and Financial Responsibility

Patient Name:_____DOB:_____/_____/_____

Responsible Party (if different from patient):

Name: _____

Relationship to Patient: _____Phone: _____

Address (if different from patient):_____

Primary Medical Insurance:

Insurance Company: _____

Policy Holder Name (if different from patient): _____

Policy Holder DOB: _____/_____/_____ Relationship to patient:_____

Primary Vision Insurance:

Insurance Company: _____

Policy Holder Name (if different from patient): _____

Policy Holder DOB: _____/_____/_____ Relationship to patient:_____

Our goal is to help you maximize your insurance benefits while making the billing process as simple as possible. As a courtesy, we will submit claims to your insurance carrier when applicable. Because insurance policies vary, we cannot guarantee coverage or payment for any service.

By signing below, you acknowledge that you are ultimately responsible for payment of all charges related to your care. We ask that any amounts due at the time of your visit be paid at the time services are provided. If we bill your insurance, any remaining balance is due upon receipt of your statement after insurance processing.

You certify that the insurance information you have provided is accurate and current, and you agree to notify Looking Out Vision, P.C. of any changes to your insurance coverage. You authorize payment of insurance benefits directly to Looking Out Vision, P.C. and authorize the release of medical information necessary to process insurance claims.

Eyewear Orders: *Payment in full is required at the time eyewear or contact lens orders are placed unless approved in advance by Looking Out Vision.*

Patient/Guardian Signature:_____Today's Date:_____/_____/_____