Precision Eye Care
651 Hwy 28 Bypass
Anderson SC 29624

Name:_____ Today's date:_____ Date of Birth:_____

Address: _____
Street City State Zip Code

Phone: (____)_____ SSN: _____ Sex: M/F

Policy Holder Information (if different from above)

Name:_____ Phone: (____)_____ Date of Birth:_____

Address: _____
Street City State Zip Code

SSN: _____ Sex: M/F

Insurance Carrier Information

Primary
Name:_____ Policy/ ID # _____

Secondary
Name:_____ Policy/ ID # _____

It is the company's policy to inform you that we may use and disclose all health information via paper, oral or electronic format to obtain payment for services. Filing a claim is not guarantee of payment. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. Please be aware that some service provided to you may not be covered by your insurance plan. All personal and health information is kept private and confidential except as required and permitted by law for billing your insurance company for payment of services

I hereby certify that I have completed this form accurately, and certify that I am the patient or authorized agent to furnish the information requested. I understand that though I have insurance coverage, I am financially responsible for all services and, when applicable, non-covered services, deductibles, and co-insurance or co-payments according to my policy benefits, as well as any insufficient funds fees, collection fees, etc. I hereby certify that the above statements are
correct and understood.

_____ _____
Signature of Patient/ Legal Guardian/Insured Date

I authorize Foothills Eye Care LLC to file a claim(s) on my behalf. I further authorize the release of medical information necessary to process such claim(s). I authorize payment of claims directly to Foothills Eye Care LLC.

_____ _____
Signature of Patient/ Legal Guardian/Insured Date

Diagnosis Information (office use only)

ICD code(s):_____ CPT code(s):_____