

INSURANCE INFORMATION

Patient's Name: _____ Date of Birth: _____
 Social Security Number: _____ Relation to Insured: Self Spouse Child

Vision Insurance

Insured Name: _____
 Birth Date: _____ Relation: _____
 Insured Employer: _____ Insurance Provider: _____
 Insured Member ID #: _____ Insured Group ID #: _____

Primary Medical Insurance

Insured Name: _____
 Birth Date: _____ Relation: _____
 Insured Employer: _____ Insurance Provider: _____
 Insured Member ID #: _____ Insured Group ID #: _____

Secondary Medical Insurance (if applicable)

Insured Name: _____
 Birth Date: _____ Relation: _____
 Insured Employer: _____ Insurance Provider: _____
 Insured Member ID #: _____ Insured Group ID #: _____

(Eye patients)

Head to Toe Healthcare PLC – Advanced Eye and Foot Care provides comprehensive medical eye exams. This includes not only vision correction but also advance screenings for other ocular conditions and systemic diseases. During your vision examination, should a medical condition arise, be advised that it is not covered under your routine eye benefits through your vision insurance plan. Medical exams are billed through your Major Medical Carrier and are subject to their specific Co-pays, Deductibles, Co-insurance and will be due at the time of service. In the event I do not wish the Doctor to proceed with a medical examination, I understand that it is my responsibility to immediately inform the doctor as she/ he can refer me to the appropriate specialty doctor.

(Eye and foot patients)

I hereby authorize any payment for my services today to **Head to Toe Healthcare PLC – Advanced Eye and Foot Care**. I understand that if my employer, insurance carrier or plan sponsor refuses payment to any portion of my claim, I am financially liable and responsible for the outstanding balance/ charges on my account. Any unpaid balance on my account or my family account is subjected to 1.5% per month interest rate or 18% per year. Should there be any legal action filed, I am responsible for the collection fees, attorney fees, filing fees, and any costs the court determines. Obtained authorization does not guarantee payment and any denied services will be billed to the patient.

Patient/ Guardian Signature: _____ Date: _____