CONNECTICUT CENTER for sight

CT CENTER FOR SIGHT - INSURANCE INFORMATION

PATIENT NAME_____DOB_____

NAME OF INSURANCE_____

POLICY #_____GROUP #_____

POLICY HOLDER'S NAME_____MALE FEMALE

POLICY HOLDER'S ADDRESS_____

POLICY HOLDER'S DATE OF BIRTH_____RELATIONSHIP TO PATIENT_____

WHAT IS YOUR COPAY FOR A SPECIALIST? _____

DOES YOUR INSURANCE REQUIRE A REFERRAL YES NO

FOR THE PURPOSE OF INFORMING US HOW WE SHOULD EXPECT PAYMENT, PLEASE ANSWER THESE QUESTIONS.

DO YOU HAVE A DEDUCTIBLE YES NO MONTH DEDUCTIBLE STARTS_____

HOW MUCH IS YOUR DEDUCTIBLE_____HOW MUCH HAS BEEN MET_____

I understand that if I have a deductible, I am responsible for paying the allowed amount that the insurance may require for today's visit.

Signature Date