INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Rose Optical
Name of Insurance Company(ies)

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Guardian or Personal Representative Date

Name of Primary Insurance: _____ ID#: _____ Group #: _____

Name of Insurance holder: _____ DOB _____ SSN _____

Relationship to patient: _____ Self _____ Spouse _____ Child _____ Other

Patient Status: _____ Full-Time Student _____ Part-Time Student _____ Employed

Name of Secondary Insurance: _____ ID#: _____ Group #: _____

Name of Insurance holder: _____ DOB _____ SSN _____

Relationship to patient: _____ Self _____ Spouse _____ Child _____ Other

Patient Status: _____ Full-Time Student _____ Part-Time Student _____ Employed