INSURANCE ASSIGNMENT AND RELEASE

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

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

_____ _____
Print Name of Patient, Guardian or Personal Representative Date

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

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