

Eye 2 Eye Optometric Center
Dr. Matthew L. Gada

Insurance Information

Please fill out the following information completely. Even if you have NO Vision coverage please fill out the Medical coverage section. We can use this information in the event that you have a visit (i.e.; eye infection, emergency visit) that may be covered by your Medical Insurance. Please be aware that your Insurance coverage is a contract between you and your Insurance Company and does NOT guarantee payment. We will gladly bill your insurance for assignment for the plans in which we are a contracted provider, for all others we will provide you with a coded receipt that you can submit to the Insurance Company for direct reimbursement. You must show your Insurance cards at each visit. Any Insurance balances not paid within 45 days of the original visit will become the responsibility of the patient to pay and then file with your Insurance Company for direct reimbursement. _____ (initial)

Patients Name: _____ DOB: ____/____/____

Vision Insurance Information

Vision Insurance Company: _____ Phone: (____) _____ - _____
Address: _____
ID #: _____ Group #: _____
Name of Subscriber: _____ DOB: ____/____/____
Address: _____ Phone: (____) ____ - ____
(If different)
Relation to Patient: _____

Medical Insurance Information

Medical Insurance Company: _____ Phone: (____) _____ - _____
Address: _____
ID #: _____ Group #: _____
Name of Subscriber: _____ DOB: ____/____/____
Address: _____ Phone: (____) ____ - ____
(If different)
Relation to Patient: _____

Secondary Insurance Information

Secondary Insurance Company: _____ Phone: (____) _____ - _____
Address: _____
ID #: _____ Group #: _____
Name of Subscriber: _____ DOB: ____/____/____
Address: _____ Phone: (____) ____ - ____
(If different)
Relation to Patient: _____

With this signature on file, I permit the staff of Dr. Gada's office to submit charges and release necessary information to my Insurance Company for reimbursement.

Signature: _____ Date: _____