

DAVID A. NELSON, O.D., P.A.
“We Focus on You”

Name: _____ **Date of Birth:** ___/___/___

Primary Insurance: _____

Name of Policy Holder: _____

Policy Holder’s Date of Birth: ___/___/___ **Relationship to Patient:** _____

Secondary Insurance: _____

Name of Policy Holder: _____

(if not the same as above)

Policy Holder’s Date of Birth: ___/___/___ **Relationship to Patient:** _____

Non-Covered Waiver of Liability

Your insurance policy may specify a coinsurance amount or have other limitations of coverage that will affect your responsibility of office charges. Also, some diagnostic tests, fitting/dispensing fees, or certain optical materials may not be covered by your insurance and will be your responsibility. Furthermore, I understand that monthly interest of 1.75% per month will be charged (\$5 minimum) on patient balances not paid within 45 days of the service date.

Assignment Consent and Release of Information

I hereby authorize David A. Nelson, O.D., P.A., to release any medical or billing information to my referring physician or to my insurance carrier and its agents to assist in processing claims, determination of benefits, or benefits payable for related services. Furthermore, I authorize payment to be made directly to David A. Nelson, O.D., P.A., for claims submitted by his office. A photostatic copy of this authorization shall be considered as effective as the original.

Patient Signature

Date

Witness Signature

Date

Please let us know who referred us to you, so we can express our gratitude.

___ Yellow Pages ___ Newspaper ___ Mailing ___ Radio ___ Insurance

___ Website ___ Professional _____ ___ Other _____