Vision & Medical Insurance Information

Vision Insurance Company_____

ID #_____

Insured's Last Name_____Insured's First Name_____

Insured's DOB_____

Relationship To Insured ( )Self ( )Spouse ( )Child ( )Other

_____

Medical Insurance Company_____

ID#_____

Insured's Last Name_____Insured's First Name_____

Insured's DOB_____

Relationship To Insured ( )Self ( )Spouse ( )Child ( )Other

I request that payment of authorized insurance benefits be made to All Eyes Optical, Inc. for any services furnished to me by Dr. Guario. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I also understand that if my insurance company does not provide payment, I will be responsible for said services.

Signature_____ Date:_____

Wellness Testing

In addition to your routine eye examination, Dr. Guario will use new technology to screen for early signs of ocular and systemic diseases such as diabetes, hypertension, glaucoma, macular degeneration, tumors, etc. This new technology includes digital retinal imaging. In order to provide you with the most complete exam, this test has now become an essential part of our complete eye health analysis.

The additional fee for this test is $39.00 and is NOT covered by vision insurance plans.

Accept □ Initials _____ Decline □ Initials_____

I acknowledge that I have received a copy of Dr. Vito J. Guario/All Eyes Optical's Notice of Privacy Practices.

Signature _____ Date:_____