

Michael Diffendall, OD.
Johanna Letts, OD.
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JACKSONVILLE

eye care

Name: Mr/Mrs/Ms/Dr _____ Jr/III Date: _____

Nickname: _____ DOB: _____

Address: _____ Sex: M / F _____

City : _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ (mobile): _____

Patient Employer: _____ Occupation: _____

Email: _____

How did you hear about us? _____

Who may we thank for referring you? _____

Vision Insurance

Insurance Carrier Name: _____

Member ID: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder DOB: _____ Policy Holder SS# (last 4 digits) XXX-XX- _____

Primary Medical Insurance

Insurance Carrier Name: _____

Member ID: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder DOB: _____ Policy Holder SS# (last 4 digits) XXX-XX- _____

Financial Policy:

Insurance coverage is an agreement between the member and their insurance company. As a courtesy we will attempt to obtain an authorization for services prior to your appointment and submit these claims to your insurance company.

This authorization is not a guarantee that services will be paid. It is ultimately your responsibility to understand the conditions of your particular plan, and you are financially responsible for any services not paid by your insurance company. Additionally, you authorize and request that insurance payments be paid directly to **Jacksonville Eye Care**.

Privacy Practices:

I hereby authorize the release of any medical or personal information necessary to process insurance claims.

Please note: At this time we do not file secondary insurance claims.

Signature on File:

Signed: _____ Date: _____