INSURANCE & FINANCIAL INFORMATION

IF YOU HAVE MEDICARE OR INSURANCE, PLEASE PRESENT CARDS AT FRONT DESK

Please be informed, the insurance company sometimes requires prior authorization. Payment for services is expected on the day of your visit. For your convenience, we accept cash, checks, and all major credit cards.

MEDICARE PATIENTS: Dr. Crump is a Medicare participating provider and therefore will accept assignment on all covered charges. You will be responsible today for the 20% co-payment, any deductible not met, and any non-covered procedures.

INSURANCE PATIENTS: Dr. Crump participates with a few select companies. If you are enrolled with one of these companies, you will be responsible for the co-payment, any deductible not met, and any non-covered procedures. If your company is not one we participate with, a form will be given to you to submit to your company for processing when applicable.

I understand and agree that, regardless of deductibles and insurance status, I am ultimately responsible for the balance on my account for any professional services rendered and agree to pay all collection and attorney fees, should my account become delinquent. I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to Dr. Jay Crump, O.D., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the health care financing administration and its agents, or my insurance company, any information needed to determine these benefits for benefits payable for related services.

I authorize reports of my evaluation and treatment's to be sent to my physician, health care providers, or hospitals that I have or will identify to you.

Signed: _____ Date: _____

Primary Insurance _____

Name of Primary Insured _____

Primary's Date of Birth _____ Social Security _____

Supplement or Secondary Insurance_____

Name of Insured _____

Date of Birth _____ Social Security _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of Jay Crump, OD's Notice of Privacy Practices in regards to the HIPPA (Health Information Patient Privacy Act) policy.

Patient Name: _____

Signature: _____

Date: _____