EAGLE EYE ASSOCIATES
4122 LBJ FREEWAY SUITE 120
DALLAS, TX 75230

Insurance information:
Medical insurance:
Who is responsible for this account: _____ relationship to patient: _____

Birthday: _____ SS#_____ Is the patient covered by additional insurance: Y N

Medical insurance Co: _____

ID: _____ group #_____

Vision insurance:
VSP Eyemed Spectera/ UHC vision Davis vision
Superior vision Avesis other:_____

Who is responsible for this account: _____ relationship to patient: _____

Birthday: _____ SS#_____ Is the patient covered by additional insurance: Y N

INSURANCE ASSIGNMENT AND RELEASE

I CERTIFY THAT I HAVE INSRUANCE COVERAGE. AND VERIFICATION DOES NOT GUARANTEE PAYMENT FROM INSURANCE COMPANIES. IF THE INSURANCE COMAPNIES FOR WHATEVER REASONS DECIDED TO DECLINE THE COVERAGE FOR YOUR SERVICE. YOU WILL BE RESPONSIBLE FOR THE CHARGES FOR THE SERVICES PROVIDED.

SIGNATURE:_____ DATE:_____

NAME:_____