DR. LAURA ANNE POTVIN
OPTOMETRISTS

INSURANCE INFORMATION

MEDICAL INSURANCE: ________________________________
VISION INSURANCE: __________________________________

OWNER OF INSURANCE: _______________________________
OWNER'S BIRTH DATE: ________________________________

OWNER'S RELATIONSHIP TO PATIENT: SPOUSE PARENT LEGAL GUARDIAN

IF PATIENT IS A MINOR, WHO IS RESPONSIBLE FOR THIS ACCOUNT:
NAME: ____
ADDRESS: ____
____
____

PLEASE SHOW US YOUR INSURANCE CARD SO THAT WE MAY OBTAIN A COPY!

Having Insurance Coverage with ____________________________________, I assign directly to Dr. Laura Anne Potvin, P.C. all vision/medical benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I hereby authorize the doctor to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all my insurance submissions.
In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare Carrier, National Heritage, as the full charge. The patient is responsible for only the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier, the difference between the approved amount and the amount paid by Medicare.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: ____
DATE: ______________________________

If my insurance requires a referral and I did not bring one, I will be responsible for payment. ***
Therefore, I will make every attempt to acquire a referral when necessary, understanding that although Dr. Laura Anne Potvin, P.C. may aid me in securing a referral, I am ultimately responsible for obtaining the referral from my primary care physician.

***As of today, if our office has not received a referral, your signature below indicates that you have received specialty care without the consent of your Primary Care Physician and that you may be financially responsible for such services.

ESTIMATED FEE FOR SERVICES RENDERED: __________________________________
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: ____
DATE: ______________________________