

**ALL EYES VISION CARE  
DR. SOSEBEE  
4965 FRIENDSHIP RD SUITE 104  
BUFORD, GA 30518  
770-932-9221**

**INSURANCE INFORMATION**

**SUBSCRIBER'S NAME** \_\_\_\_\_  
**ID OR SS#** \_\_\_\_\_ **DOB** \_\_\_\_\_  
**RELATIONSHIP TO PATIENT** \_\_\_\_\_

**INSURANCE POLICIES: (PLEASE READ & SIGN)**

**Professional services are rendered and charged to you, not the insurance company. Please understand that any insurance contract is between you and the insurance company and payment for these services and materials are ultimately your responsibility.**

**All co-payments and fee amounts not covered by insurance are due at the time of treatment.**

**Our office will file and collect insurance claims if we are contracted providers with that insurance company. We do our best to verify insurance and benefits before services are rendered. However, if your insurance is canceled or you provide false or incorrect information to us about your insurance, you will be held responsible for the entire balance owed. Upon request, we will supply you with a copy of the claim so that you can resubmit as necessary.**

**In order to honor any insurance benefits, you must provide insurance identification and we must be able to verify the current benefits available.**

**ASSIGNMENT & RELEASE:**

**I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to ALL EYES VISION CARE all insurance benefits. Further, despite my insurance coverage, I understand that I am financially responsible for all charges incurred. I hereby authorize the doctor to release ALL information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.**

**I HAVE READ & I UNDERSTAND THE STATEMENT OUTLINES ABOVE.**

**SIGNED:** \_\_\_\_\_ **DATE** \_\_\_\_\_