# INSURANCE INFORMATION

INSURANCE COMPANY _____

Primary Insured person's name

Name_____

Social Sec. # _____

Birthday_____

Employer_____

Relationship to Patient _____

Secondary Insured person's name

Name_____

Social Sec. # _____

Birthday_____

Employer_____

Relationship to Patient _____

**ASSIGNMENT AND RELEASE**

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named company and assign directly to Lally Vision Care, P.C. all insurance 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 insurance submissions.

_____

Responsible Party Signature

_____

_____

Relationship to insured person Date