Head to Toe Healthcare, PLC®
Advanced Eye and Foot Care

7406 N. La Cholla Blvd
Tucson, Arizona 85741
520-545-0202
www.headtotoehealthcare.org

INSURANCE INFORMATION

Patient's Name: ____________________ **Date of Birth:** _____/_____/_____
Social Security Number: ________-_____-________

VISION INSURANCE

Insurance Provider: ____________________
Member ID #: ____________________ **Group #:** ____________________
Insured Name: ____________________ **Insured Birth Date:** _____/_____/_____
Insured Employer: ____________________ **Relation to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

PRIMARY MEDICAL INSURANCE

Insurance Provider: ____________________
Member ID #: ____________________ **Group #:** ____________________
Insured Name: ____________________ **Insured Birth Date:** _____/_____/_____
Insured Employer: ____________________ **Relation to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

SECONDARY MEDICAL INSURANCE (IF APPLICABLE)

Insurance Provider: ____________________
Member ID #: ____________________ **Group #:** ____________________
Insured Name: ____________________ **Insured Birth Date:** _____/_____/_____
Insured Employer: ____________________ **Relation to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

☐ **Was the HIPPA – Notice of Privacy Practices form made available to you? __________(Please initial)**

(Eye patients)

Head to Toe Healthcare PLC – *Advanced Eye and Foot Care* provides comprehensive routine and medical eye exams. This includes not only vision correction but also screenings for other ocular conditions and systemic diseases. During your vision examination, should a medical condition arise, be advised that it is not covered under your routine eye benefits through your vision insurance plan. Medical exams are billed through your Major Medical Carrier and are subjected to their specific Co-pays, Deductibles, Co-insurance and will be due at the time of service. In the event that I do not wish the Doctor to proceed with a medical examination, I understand that it is my responsibility to immediately inform the doctor as she/ he can refer me to the appropriate specialty doctor.

(Eye and foot patients)

I hereby authorize any payment for my services today to Head to Toe Healthcare PLC – *Advanced Eye and Foot Care*. I understand that if my employer, insurance carrier or plan sponsor refuses payment to any portion of my claim, I am financially liable and responsible for the outstanding balance/ charges on my account. Any unpaid balance on my account or my family's account is subjected to 1.5% per month interest rate or 18% per year. Should there be any legal action filed, I am responsible for the collection fees, attorney fees, filling fees, and any cost the court determines. Obtained authorization does not guarantee payment and any denied services will be billed to the patient.

Patient/ Guardian Signature: ____________________ **Date:** _____/_____/_____