Eyes of Chicago

3015 E. New York St. A4
Aurora, IL 60504

Release of Information

You may release any/and all information to the following family members (Name/Relationship):

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Insurance Verification

You are **financially responsible** for all services, product charges, should your insurance consider any of these charges to be non-covered expenses. **Insurance** is not a guarantee of payment. Any and all refunds are processes at the end of each month.

Insurance coverage is the patient's responsibility. For any services other than routine eye coverage, we will bill your insurance company. If for any reason the claim is denied, you are responsible for payment in full.

Insurance must be presented at time of service. We will no longer be able to process any insurance and/or discounts at a later date.

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Initial

Notice of Privacy Practices

I acknowledge and have been made aware that Eyes of Chicago has a Notice of Privacy Practices, a copy which has been offered for inspection.

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Initial

Responsibility Statement/Acknowledgement of Privacy Practices

This form permits our office to computer generate, electronically file and/or personally file any and all claims pertaining to any visual insurance claim.

I, the patient, and/or responsible party, give permission to Eyes of Chicago, to release any information necessary to file for my insurance. I am fully aware that neither confidential information, nor any other information not routinely needed to filing my insurance will be released.

_____
Date

_____
Please Print Patient's Name

_____
Signature of Patient/Guardian