



Oculoplastic Consultants of Central PA, P.C.
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INSURANCE INFORMATION:
 (Please complete in blue or black pen)

Patient Name: _____

Is this a Worker's Comp or an Auto Claim? _____ (If yes, please see receptionist for additional form)

Primary Insurance Co. _____ **I.D.#** _____

Subscriber's Name _____ **Group#** _____

If the subscriber is different than the patient, please fill out the following information:

Subscriber's I.D.# _____ **Social Security #** _____

Date of Birth _____ **Relationship to Patient** _____

Employer _____

Do you need a referral? _____ **Amount of Copay?** _____

Secondary Insurance Co. _____ **I.D.#** _____

Subscriber's Name _____ **Group#** _____

If the subscriber is different than the patient, please fill out the following information:

Subscriber's I.D.# _____ **Social Security #** _____

Date of Birth _____ **Relationship to Patient** _____

Employer _____

Do you need a referral? _____ **Amount of Copay?** _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid by your insurance. We request that copays for office visits be paid at the conclusion of each visit unless you are covered by Medicare.**

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Guardian Signature _____ **Date** _____

Updated on _____ **Initials** _____
Updated on _____ **Initials** _____