



**COMPLETE  
EYE CARE**

seemorelivebetter.com

Dr. Chris Swanson Dr. Timothy Snider Dr. Larry Silkey Dr. Shane Claborn

**INSURANCE ASSIGNMENT & RELEASE**

▶ Patient Information

Name: \_\_\_\_\_

S.S.#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

▶ Insured Person Information

Insured Person Responsible: \_\_\_\_\_

S.S.#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Insured I.D.#: \_\_\_\_\_ Group/Policy#: \_\_\_\_\_

▶ Acceptance of Financial Responsibility

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Complete Eye Care 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 Person Signature

\_\_\_\_\_  
Date

**Do you have any other Insurance (including Medicare)? Yes No**

You must circle one.

Please List: \_\_\_\_\_