Dr. David MacDonald
Cartier Optical, Inc.
Old Saybrook, CT

# INSURANCE

Name: _____ D/O/B: _____ Marital Status: M S D W
Street address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Alt #: _____
E-Mail Address: _____

## Primary Insurance

Insurance Holder Name: _____
Relationship to Patient: _____
Insurance Holder D/O/B: _____
Insurance Company Name: _____
Member ID: _____ Group #: _____

## Secondary Insurance

Insurance Holder Name: _____
Relationship to Patient: _____
Insurance Holder D/O/B: _____
Insurance Company Name: _____
Member ID: _____ Group #: _____

**Agreement and Release**

I certify that I, and/or my dependent(s) have insurance coverage with _____. And assign directly to Dr. _____ 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 authorize the use of my signature on all insurance submissions.

The above name doctor may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefit payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

**Signature of patient, parent, guardian, or personal representative** **Date**

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