



**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Primary Insurance Information**

Company Name \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Relationship \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc Sec # \_\_\_\_-\_\_\_\_-\_\_\_\_

Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Insurance Information**

Company Name \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Relationship \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc Sec # \_\_\_\_-\_\_\_\_-\_\_\_\_

Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Insurance Payment Authorization**

I authorize Timothy B. Cavanaugh, MD and/or his representatives to file my primary and secondary insurance and receive payment for services rendered. I also understand that I am responsible for any balance that is not paid or covered by my insurance.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Patient Payment Authorization**

I understand that I do not have insurance or that Dr. Cavanaugh is not a provider with my insurance. I understand that I will be responsible for any balance that is not covered.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Medicare Lifetime Authorization**

I request the payment of authorized Medicare benefits be made on my behalf to Cavanaugh Eye Center, PA for services furnished to me by Timothy B. Cavanaugh, MD or other doctors and staff of the practice. I authorize any holder of my medical information to release to HCFA and its agents any information needed to determine benefits or benefits payable for related services.

I understand that I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon charge determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary or Authorized Signature

\_\_\_\_\_  
Date