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Financial Responsibility Form

Attention:

Positive verification of your medical coverage cannot be determined at this time.

You will be receiving services today with the understanding that in the event that your coverage is not applicable, you will be billed and held financially responsible for the services rendered.

Please fill out the necessary medical information in order to determine eligibility:

Patient's Name: _____ DOB _____

Social Security Number (subscriber): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Subscriber's Name: _____ Subscriber's DOB _____

Relationship to subscriber: _____

Employer's Name (subscriber): _____

Vision Care Insurance: _____

Medical Insurance Company: _____

I have read and filled out the above insurance information. I understand my possible responsibility and hereby affix my signature as an acknowledgement of this understanding.

Patient Signature: _____ Date: _____