Dr. Arthur Friedman
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Precision Medical Information Systems
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Precision Medical Information Systems, LLC

Patient Information:

First Name:_____ Last Name:_____

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

Home Phone:_____ Work Phone:_____ Cell:_____

SSN:_____ Sex:_____ Birthdate:_____ Marital Status:_____

Responsible Party Information: (if different from above)

First Name:_____ Last Name:_____

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

Home Phone:_____ Work Phone:_____ Cell:_____

SSN:_____ Sex:_____ Birthdate:_____ Marital Status:_____

Insurance Information:

Primary Insurance Company: _____

Subscriber Name:_____ ID Number:_____

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

Group Number:_____ Relationship to Insured:_____

Secondary Insurance Company: _____

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

Subscriber Name:_____ ID Number:_____

Group Number:_____ Relationship to Insured:_____

***** YOU are responsible for providing correct and complete insurance information *****

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or depends. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim:

I _____ hereby authorize _____ to pay and hereby assign directly to
(Name of Insured) (Name of Insurance Company)

Dr. Arthur Friedman OD/Arte of Vision, LLC all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dr. Arthur Friedman OD/Arte of Vision, LLC will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

***** Please make a copy (front and back) of all insurance cards and attach to this document *****