

*Steven W. Rosenak, O.D.  
Dr. Rosenak's Optical Options  
2229 A North Belt Highway  
St. Joseph, Missouri 64506*

Please take the time to fill out this Insurance form in order that we can correctly file your insurance. If you have any questions, please ask our staff for assistance.

Who is responsible for this account ? \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Group # \_\_\_\_\_

- Is patient covered by additional Insurance? \_\_\_yes \_\_\_no
- Subscriber Name \_\_\_\_\_
- Birthdate \_\_\_\_\_ SS# \_\_\_\_\_
- Relationship to Patient \_\_\_\_\_ Insurance CO. \_\_\_\_\_
- Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Rosenak 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 Party Signature \_\_\_\_\_
- Relationship \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for your kind attention in filling out this form. Your reward is a piece of our delicious candy on the front desk.

**Steven W. Rosenak, O.D.**