Newberg Vision Clinic PC
Jeremy W. Taylor, OD
Paula A. Taylor, OD
2207 A Portland Rd
Newberg, OR 97132

Patient Insurance Agreement

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Patient's legal name | Male/Female | Date of Birth

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Preferred Name or Nickname if different than above

Insurance will be billed for you as a courtesy by Newberg Vision Clinic.
Please provide primary insurance information or provide insurance card to copy.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits to the physician or supplier for services rendered.
Disclaimer: I AGREE TO PAY ANY EXTRA CHARGE THAT IS OVER AND ABOVE THE ALLOWANCE PAID BY MY INSURANCE COMPANY. I ALSO AGREE THAT I AM FINANCIALLY RESPONSIBLE IF THE INSURANCE COMPANY DENIES MY CLAIM.

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Signature of Responsible Party | Date

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Printed Name | If applicable list relationship to patient