MEDICAL RELEASE/ LIFETIME SIGNATURE ON FILE/
PAYMENT AUTHORIZATION

I authorize payment of all Medicare or other insurance benefits for services rendered by this office to be made payable to the doctors in this office. I authorize this office to release to the Health Care Financing Administration and its agents and any other insurer any information necessary to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for all charges not covered by my insurance benefits. I hereby give my consent for myself or my child to be examined. I understand that my eyes may be dilated during the examinations. If a refraction (the part of the exam that determines your need for eyeglasses) is necessary, Medicare and certain other insurance carriers will/may disallow it, stating that it is not a covered Medicare Insurance benefit. Therefore, I will be responsible for the refraction charge as well as for any other "non covered" services under Medicare and other private insurance plan. In the case where multiple insurance benefits may be applied, this office reserves the right to choose which insurance may be deemed primary. In the event that multiple insurance benefits apply, this office will limit their filing to two separate filings with myself being responsible for any further filings. I understand that I am responsible for knowing my insurance and if the provider participates in that plan and is considered in or out of network.

Signature________________________________Relationship_____________________Date_________