

MEDICARE, MEDICAID, BLUE CROSS/BLUE SHIELD, VSP AND ALL OTHER INSURANCE PATIENTS/NON-INSURANCE PATIENTS:

“I authorize any holder of medical or other information about me to be released To the Social Security Administration and Health Care Administration (for Medicare patients) or to my insurance company and/or its’ intermediaries, any Information needed for related claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment.”

In the event of a denial or rejection of this claim by my insurance company, I Understand that the payment of said claim will be my responsibility.

Medicare and Medicaid patients are responsible for \$20.00 refraction fee that is not covered.

I acknowledge that I received a copy of the Notice of Privacy Practices.

_____ Date _____
Signature of Guarantor

I hereby give approval to disclose any or all of my medical

information to _____
Name Relationship

Signature of Patient