vitaleyes

INSURANCE AUTHORIZATION - SIGNATURE ON FILE

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) related to any and all health benefits due to me and my dependents.

I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

_____ _____

Today's Date Signature of Patient or Insured

The Signature on File (SOF) is valid from this date and expires in thirty-six months. A photocopy of this authorization may act as an original.

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