Authorization to Bill Insurance Company
for payment of physician services

Subscriber's Name_____
Date of Birth_____

PCP:_____ Telephone:_____

Referral #:_____ Date:_____
# of Visits:_____

I request that payment of authorized insurance benefits be made to me or on my behalf to Eyecare-Eyewear Assoc. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to my insurance company and its related services. I am aware that I am responsible for any disallowed or unpaid balances, including my deductable by this insurance company. **If you participate with an HMO which requires a referral or you are told that you may need a referral for your appointment with us, it is *YOUR* responsibility to contact your primary care physician prior to your eye appointment date, to request a referral. If you fail to get a necessary referral, you are responsible for all charges not covered by your insurance company.**

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Signature of Beneficiary