AUTHORIZATION TO BILL INSURANCE

I, _____, request that payment of authorized insurance benefits be made on my behalf to Dr. Jeffrey Garcia, O.D. for any service furnished to me or my dependents by Dr. Garcia. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand that my records are confidential. I understand that by signing this consnt form I am allowing my medical information to be released to my insurance company upon their request.

I permit a copy of this authorization to be used in place of the original.

_____ _____

Date **Signature (Patient, Parent or Guardian)**

PRIVACY POLICY

The privacy of your medical information is important to us. We understand that your medical information is person and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements.

FEE POLICIES

- Please make the receptionist aware of your health care or vision insurance plans and let us make a copy of your card.

_____ I understand that if I am not using insurance, office visits, eye exams, contact lens fittings and contact lens training must be
Initial paid in full at the time of service.

_____ I understand that if I am using insurance, any copays must be paid in full at the time of service
Initial

_____ The patient is responsible for any fees after insurance (glasses overvages, contact lens fitting and training fees, overages for
Initial boxes of contacts). Upon request, we will provide you with a receipt which has all the information required so you may submit it to your insurance if you wish.

By signing below, I certify that I have read and understand the fee policies and agree to pay for any services rendered.

_____

Signature (Patient, Parent or Guardian)