Note: Most insurance policies pay only a portion of your total charges. We do not guarantee the accuracy of benefit information give to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. Please be advised that you the patient are responsible for any balance the insurance does not pay.

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to **Three Rivers Optometric Group** for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

____________________________________ ____________________________

Lifetime Patient Signature Date