

## **Contact Lens & Vision**

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### **Medical Release/Lifetime Signature on File/Payment Authorization**

I authorize payment for all Medicare and/or other insurance benefits for services rendered by this office be made payable to the doctors in this office. I authorize this office to release to the Centers for Medicare and Medicaid and its agents or any other insurer any information necessary to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. This form will serve as a lifetime signature form.

I understand that I am responsible for all charges not covered by insurance benefits. Medicare and other insurance companies do not pay for the refractive part of the examination. If refraction (the part of the exam that determines your need for eye glasses) is necessary, Medicare and other insurance carriers will disallow it, stating that it is not a covered Medicare/Insurance benefit. Therefore, the patient will be responsible for the refraction charge as well as for any other “non-covered” services under Medicare and any other private insurance plan. I understand that I will be responsible for co-payments and deductibles and for services not covered by my insurance plan including Medicare.

I hereby give my consent for me or my child to be seen. I understand that my eyes may be dilated during examinations.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_