



SIGNATURE AND AUTHORIZATION FORM

BASIC INSURANCE INFORMATION:

PRIMARY INSURANCE & ID NUMBER _____

SECONDARY INSURANCE & ID NUMBER _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

Please check all that apply: I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct.

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.

MEDICARE WAIVERS: (if applicable)

- I understand that medicare will not allow the refractive service and that I will be responsible for the fee of \$15.00.
- I understand that Medicare will only pay for lenses and/or frames one time after cataract surgery.
- I understand that Medicare will only cover 80% of up to \$50.00 towards a frame and I have selected a frame with a higher price and that this is considered a deluxe frame and I am responsible for the difference of \$_____.

PRIVACY ACT COMPLIANCE: I give my consent to be contacted by the following methods regarding appointments, recall, glasses, contact lenses, or treatment by Sites Vision Clinic:

- Telephone
- Mail
- E-mail
- By leaving a message for me at home, work or on an answering machine.

Signature: _____ Date: _____