INSURANCE AUTHORIZATION

PATIENT AGREEMENT

I, the undersigned, realize that I am financially responsible for all services rendered to me by Klessman & Rosenblatt, O.D., P.C., dba. Washington Eye Doctors (the Practice).

For those insurances for which the Practice accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage.

I, the undersigned, hereby authorize Washington Eye Doctors to apply for benefits for covered services rendered by the Practice, and request that the payments from Medicare Part B, Vision Service Plan and/ or my insurance carrier be paid directly to the Practice. I certify that the information that I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier(s) (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient or Guardian Date

ptagree