## INCOMPLETE INFORMATION WILL RESULT IN YOUR ACCOUNT BEING CONSIDERED "SELF PAY"

Name of Patient:_____
Name of Vision Insurance:_____
Member #_____ Group#_____
Name of Member_____ Relationship_____
Member's Social Security #_____Member's DOB_____
Member's Employer_____

Name of Medical Insurance:_____
Member #_____Group#_____
Primary Care Doctor_____Phone #_____

If you plan to pay by check, we will need your driver's license number to get authorization through Telecheck: #_____

## ASSIGNMENT OF BENEFITS

I request that payment of authorized benefits be made on my behalf to Professional Eye Care Center for any and all services and/or products received by me. I authorize any holder of medical information about me to release to Professional Eye Care Center and its agents any information needed to determine these benefits or the benefits payable for related services.

I certify that the information I have reported with regard to myself and my insurance coverage is correct and this assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Professional Eye Care Center will adhere to the eligibility and benefits under guidelines provided by your insurance company. Please realize that we cannot guarantee payment of claims.

Professional Eye Care Center will file my insurance claim with the information provided by me; however, the responsibility for the charges remains with me and fees must be paid by the due date, regardless of whether or not the fees are paid by my insurance company.

___ I hereby agree to this provision.

___I understand that I have the choice NOT to assign benefits and that the fees for the services and materials provided today are due at the end of the office visit.

SIGNATURE_____DATE_____