

**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 # _____

Your Driver's License #: _____

ASSIGNMENT OF BENEFITS

I request that payment of authorized benefits be made on my behalf to Professional Eyecare 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 Eyecare 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 Eyecare Center will adhere to the eligibility and benefits under guidelines provided by your insurance company. Please realize that we cannot guarantee payment of claims.

I understand that I am financially responsible for all charges, whether or not paid by insurance. Professional Eyecare Center will file my insurance claim with the information provided by me, however the responsibility for the charges remains with me and must be paid by the due date, regardless of insurance. I hereby agree to this provision.

SIGNATURE: _____ **DATE:** _____