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

Name of Patient:	
Name of Vision Insurance:	
Member #	Group#
	Relationship
Member's Social Security #	Member's DOB
Member's Employer	
Name of Medical Insurance:	·
Member #	Group#
Primary Care Doctor	Phone #
	d your driver's license number to get authorization
ASSIGNMENT OF BENEFITS	
Center for any and all services and/or p medical information about me to release information needed to determine these I certify that the information I have rep- is correct and this assignment will rema- of this assignment is to be considered a Professional Eye Care Center will adher	enefits be made on my behalf to Professional Eye Care products received by me. I authorize any holder of se to Professional Eye Care Center and its agents any elebenefits or the benefits payable for related services. Orted with regard to myself and my insurance coverage ain in effect until revoked by me in writing. A photocopy is valid as an original. The to the eligibility and benefits under guidelines Please realize that we cannot guarantee payment of
however, the responsibility for the char	ny insurance claim with the information provided by me; rges remains with me and fees must be paid by the due fees are paid by my insurance company.
I hereby agree to this provision.	
I understand that I have the choice and materials provided today are due a	NOT to assign benefits and that the fees for the services at the end of the office visit.
SIGNATURE	DATE