Iberia Vision Center

RELEASE OF INFORMATION, GUARANTEE OF PAYMENT, SIGNATURE FOR FILE:

I authorize Iberia Vision Center to release to the Social Security Administration, Centers for Medicare & Medicaid Services, its intermediaries or my medical/vision insurance carrier any information needed for a medical/vision claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical/vision insurance benefit either to myself or to Iberia Vision Center.

Insurance companies do not guarantee payment. In the event the services I receive in this office are not covered by my insurance, I understand that I am responsible for all unpaid charges, and further agree to pay any and all costs associated with these fees.

The HIPAA Privacy Act requires us to keep your medical information private. Please sign acknowledging that you were offered a copy of the HIPAA document/Privacy Policy, and have given your consent for our office to verify, authorize and file insurance claims for your and/or your dependents behalf.

PRINT NAME OF PATIENT OR RESPONSIBLE PARTY_____

SIGNATURE:_____Date:_____