Northwest Eye Physicians, P.C.

Patient Insurance Signature on File

Patient Name_____:
Print Name Here

I hereby authorize Northwest Eye Physicians/my doctor to collect insurance benefits otherwise payable to me, by helping me obtain payment of my insurance benefits, and I authorize payment of these benefits directly to Northwest Eye Physicians/ Dr. _____ on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I also understand that I am responsible for all expenses relative to services/treatments performed.

_____ _____
Patient / Responsible Party Signature Date