## Lifetime Insurance Signature on file

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me with payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Jeffrey S. Nevitt, OD on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing 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.

*If my insurance denies the services billed because benefits were not eligible, I will accept full responsibility for payment in full.*

______________________________ ____________

*Lifetime Patient Signature* *Date*

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Pacific Eye Clinic's Notice of Privacy Practices

By my signature below I acknowledge receipt of the Notice of Privacy Practices:

______________________________ __________

*Signature* *Date*

*By signing below, I give Pacific Eye Clinic permission to leave a message when contacting me by phone and to release medical information to the following:*

- ❑ **Spouse**
- ❑ **Parents**
- ❑ **Children**
- ❑ **Care Giver – Name(s):**
- ❑ **Other:**

__________________________ ____________

*Signature* *Date*