INSURANCE AUTHORIZATION SIGNATURE FORM

INSURANCE

Due to the many insurance plans, *our staff cannot guarantee your eligibility and coverage*. It is the patient's responsibility to verify benefits and eligibility prior to your visit. Not all plans cover all charges and choices in eyewear. Please be aware of your plan limitations. We are participating providers with many insurance plans. We will file an insurance claims on your behalf. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. Please remember, *insurance is a contract between the patient and the insurance company* and ultimately the patient is responsible for payment in full. If we later receive payment from your insurer, we will refund any over payment to you.

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I hereby authorize Optical Factory and Showroom, Inc. or Ronald G. Tucker O.D., P.A. to release any medical or other information necessary to process my insurance claims.

I am requesting payment of services to be paid directly to Optical Factory or Ronald G. Tucker O.D., P.A. either party that accepts assignment.

Any charges not covered by insurance are the sole responsibility of the patient. Payment is expected upon receipt of insurance denial.

I have read, understood, and agreed to the above financial policy for payment of fees.

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Signature of patient / parent of minor patient Date