

Los Gatos Eye Care



15563 Union Avenue
Los Gatos, CA 95032
408-377-2020 Phone
408-377-2022 Fax

SIGNATURE ON FILE

Claim Number _____

NAME OF INSURED: Last _____, First _____.

NAME OF PATIENT: Last _____, First _____.
(If other than insured)

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of services.

I hereby authorize payment directly to Dr. Ilene Polhemus O.D., for any services rendered to me by Dr. Ilene Polhemus O.D., or any of her authorized agents.

I authorize the release of all medical information to the insured's health insurance carrier that is: 1) acquired in the course of my examination or treatment and 2) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Dr. Ilene Polhemus O.D., or any of her authorized agents to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

DATE