Family Eye Care Clinic P.C.
Modern Technology with Old Fashioned Caring

Dr. Randal M. Cox
Therapeutic Optometrist

Dr. Terry D. Foster
Therapeutic Optometrist

Dr. Adam R. Cox
Therapeutic Optometrist

INSURANCE SIGNATURE/AGREEMENT FORM

Thank you for choosing Family Eye Care Clinic for your eye health needs.

It is mandatory for all insurance companies/Medicare/Medicaid to have signatures on file for billing purposes. In order to respond to insurance inquiries in a timely manner and to avoid unnecessary trips to our office, we need your signature.
Please sign and date below.

LIFETIME SIGNATURE AUTHORIZATION FORM

I, the insured, understand that all insurance claims filed on my behalf by Family Eye Care Clinic, P.C. are filed as a courtesy and that I am responsible for payment of services not covered under my applicable benefit plan and for charges that apply to my deductible. I also understand that all co-pays and coinsurance amounts are due at the time services are rendered.

I hereby request that payment of authorized Medicare or any insurance benefits be made either to me or on my behalf to Family Eye Care Clinic, P.C., for any services furnished to me be Family Eye Care Clinic, P.C.. I authorize any holder of medical information about me to release to the Centers of Medicare & Medicaid Services or any other insurance carrier, their agents and carriers, any information needed to determine these benefits or the benefits payable for related services now or in the future.

MEDICARE RECIPIENTS:

Family Eye Care Clinic, P.C. accepts the charge determination of the Medicare carrier as the full charge, and I'm responsible only for the deductible, coinsurance and the non-covered services.

_____
Printed name of insured or Authorized cardholder

_____ _____
Signature of insured or Authorized cardholder **Date**

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