CLV
Contact Lens & Vision

MEDICAL RELEASE/LIFETIME SIGNATURE ON FILE

I authorize payment for all insurance benefits for services rendered by this office be made payable to doctors in this office. I authorize Contact Lens and Vision Consultants to release my information necessary to determine the benefits payable for related services to the appropriate insurance agencies. I permit a copy of this authorization to be used in place of the original. This form will serve as a lifetime signature form.

I hereby give my consent for me or my child to be seen.

Signature: _____Date: _____

CREDIT CARD AUTHORIZATION FORM

I understand that I am responsible for all charges not covered by insurance benefits.
Some insurance companies (including Medicare) do not pay for the refractive part of the examination. If refraction (the part of the exam that determines your need for eye glasses) is necessary, these insurance carriers will deny the claim, stating that it is not a covered Medicare/Insurance benefit.

Therefore, I, the patient will be responsible for the refraction charge (if not covered by my insurance) as well as for any "non-covered" services. I understand that I am responsible for co-payments and deductible and for services not covered by my insurance plan. If no response of made after three consecutive bills sent to me, I authorize Contact Lens and Vision Consultants to automatically charge to my credit card on file remaining fee(s).

PLEASE CIRCLE CARD TYPE: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

_____ _____ / _____ _____
CREDIT CARD ACCOUNT NUMBER **EXP. DATE** **SECURITY CODE**

_____
PATIENT NAME

_____
CARDHOLDER NAME

_____ _____ _____ _____
CARDHOLDER ADDRESS **CITY** **STATE** **ZIP CODE**

X _____ _____
CARDHOLDER SIGNATURE **DATE**