125 S. Frontage Rd.
Nipomo, Ca 93444
Ph: (805) 929 - 1982
Fax: (805) 929 – 5052

SIGNATURE ON FILE

Name of insured: ____

Name of Patient: ____

I understand and I agree that I am responsible for 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 insured expenses not covered by the insured's health carrier must be paid for at the time of services.

I hereby authorize payment directly to Nipomo Optometry, for any services rendered to me.

I authorize the release of all medical information to the insured's health insurance carrier that is acquired in the course of my examination or treatment.

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