

MEDICAL RELEASE/LIFETIME SIGNATURE ON FILE/PAYMENT AUTHORIZATION

I authorize payment for all insurance benefits for services rendered by this office be made payable to Dr. Kowalsky.

I authorize Family Vision Care to release any 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 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 eyeglasses) is necessary, these insurance carriers will deny the claim, stating that it is not a covered Medicare/Insurance benefit. Therefore, the patient will be responsible for the refraction charge as well as for any other "non-covered" services.

I understand that I will be responsible for co-payments and deductibles and for services not covered by my insurance plan.

I hereby give my consent for me or my child to be seen. I understand that my eyes may be dilated during examinations.

Print Name: _____

Signature: _____

Date: _____