

Michael P DeCarlo Optometrist Inc.

Signature on File

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my insurance companies.

I understand that I am responsible for my bill and or any balance left unpaid by my insurance.

I authorize Michael P DeCarlo Optometrist Inc. to act as my agent in helping me obtain payment from my insurance company.

I authorize payment direct to Michael P DeCarlo Optometrist Inc.

I permit a copy of this authorization to be used in place of the original.

I understand that all professional fees are due at the time services are rendered and are non-refundable.

I understand all sales of contact lenses and optical goods are final and non-refundable.

Patient Name _____

Patient/ Guardian Signature _____

Date _____