EYE BOUTIQUE OF SEDONA

INSURANCE SIGNATURE ON FILE

I require that payment of authorized Medicare benefits be made on my behalf to:

Eye Boutique of Sedona
Dr. Carolyn Martin
100 Verde Valley School Rd Suite #114
Sedona, AZ 86351

for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits for the benefits payable to related services. I understand my signature (#2 below) requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approval claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In assigned cases, the provider or supplier agrees to accept the charge determination of the insurance carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the insurance carrier.

1. PATIENT'S NAME (Please Print):____

2. PATIENT'S SIGNATURE: ____