SIGNATURE ON FILE

Medicare, Medigap and Other Insurance

I request that payment of Medicare benefits be made on my behalf to Albemarle Eye Center, PLLC for services furnished me by Albemarle Eye Center, PLLC. I authorize any holder of medial information about me to release to the CMS and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If Medigap or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to Albemarle Eye Center, PLLC

_____ _____

Signature Date

Other Insurance

I hereby authorize payment of any medical and surgical insurance benefits to Albemarle Eye Center, PLLC. I understand I am financially responsible for any charges whether or not paid by said insurance. If my insurance company or health plan designates co-payments and or deductibles, I agree to pay them to Albemarle Eye Center, PLLC. I authorize Albemarle Eye Center, PLLC to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____

Signature Date