Patient Financial Responsibility

I hereby authorize Elite Eyecare & Optical to apply for benefits on my behalf for covered services rendered by the. I also assign my benefits and request that all payments from _____ *(insurance company)* be made directly to the vision care provider. I agree to assume responsibility of full payment pending any remaining balance that is not covered by said insurance company.

I certify that the information I have reported with regard to my coverage is correct. I further authorize Elite Eyecare & Optical to release to said insurance company and its agents any information related to this or any claim.

X_____DATE_____
Patient or Guardian's Signature

Relationship to patient_____