



## Insurance Payment Authorization/Signature On File Authorization

Primary Medical Insurance Company \_\_\_\_\_

Secondary Medical Insurance Company \_\_\_\_\_

Vision Plan (if applicable) \_\_\_\_\_

I hereby authorize you (insurance company[s]) to pay directly to the below named office, benefits due me out of indemnity under the terms of my policy issued by your company.

### Vision Salon Eye Care Associates

**12812 S. Western Ave.  
Blue Island, IL 60406**

**840 E. 87<sup>th</sup> St., Ste 100  
Chicago, IL 60619**

I authorize the use of this form for medical insurance submissions, and release of information with payment made directly to the doctor. I permit a copy of this to be used in place of the original. Payment of this amount as herein directed, in whole or part, shall be considered the same as if paid, by your company, directly to me (the insured).

<b>Insured Name:</b>	<b>Social Security #:</b>		
<b>Primary Ins. Policy #:</b>	<b>Secondary Ins. Policy #:</b>		
<b>Primary Ins. Group # (if applicable):</b>	<b>Secondary Ins. Group # (if applicable):</b>		
<b>Address:</b>			
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	

### Insurance Billing Policies

1. I understand that I am ultimately responsible for payment in full for services provided by the doctor and the Vision Salon, Ltd. Use of insurance within the guidelines of my medical or vision insurance policy is permitted.
2. In the event of default, declines, or rejection of claims by me or my insurance carrier, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt.
3. The staff of the Vision Salon will assist as possible in your insurance claims. Your eventual reimbursement or coverage will be determined by your insurance carrier. Any deductibles or co-payments are due at the time of service or immediately upon notification of this office.

I agree to the above billing policies and authorization for billing.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_

Relationship to patient \_\_\_\_\_