Lincoln Optometry

Insurance Signature On File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. *I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits,* and I authorize payment of these benefits directly to Michael H. Pontius, O.D. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated on the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Signature: ____

Date: ________________________

*******The undersigned will ultimately be responsible for any bill incurred in this office regardless of

Insurance. I understand that all benefits quoted to me are not a guarantee of payment by my Insurance Company and that final determination can only be made when claim is processed.