CATARACT & LASER
EYE SURGEONS

Patient Name	
Home Address	
City, State and Zip	
Phone	
Email	
Employer	
Employer Address	

Primary Ins.		Secondary Ins.	
Address		Address	
Policy #		Policy #	
Group#		Group#	
Policy Holder Name		Policy Holder Name	
Date of Birth		Date of Birth	
Social Security #		Social Security #	
Relation to insured		Relation to insured	

I authorize payment of medical benefits to Michael Sayegh, MD, Bernadette McDougall, MD or Eric Fitz, MD for services rendered. I authorize this office to furnish the Health Care Finance Administration and its agents or my insurance carriers with any information relevant to my claim, and to receive direct payments, when assignment is accepted, of benefits otherwise payable to me. I permit a copy of this authorization to be used in place of the original.

I understand that some services I want the doctors to provide may not be covered by my insurance plan, such as exam for glasses, lid plastic surgery, potential acuity, corneal and thyroid measurements and refractive surgery. Payment may be denied for insurance reasons as well. In these instances, I agree to be personally responsible for payment. I authorize my physician to appeal any payment denial on my behalf.

I do not have or need a referral form from my primary care physician. However, if insurance payment is denied for this reason, and I do not obtain a required referral form, properly dated, then I will be responsible for payment of these charges and can be billed directly.

By signing below, I acknowledge that I have access to and have been offered a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Cataract & Laser Eye Surgeons and how I may obtain access to and control this information.

SIGNATURE_____**DATE**_____