

Insurance Signature

D. A. Brodmann, O.D.

Patient Name: _____

I certify that the information given by me in applying for insurance and/or Medicare/Medicaid 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/Medicaid benefits, and I authorize payment of these benefits directly to D. A. Brodmann, OD on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the HCFA-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. Furthermore, I agree to pay for any fees that my insurance company has denied and deems is my responsibility, or any payments that are due to the provider that have been credited towards my deductible, or for any materials or services that were rendered outside my dates of coverage.

X

Signature

Date