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Website: [www.CorneaAZ.com](http://www.CorneaAZ.com)

## **LIFETIME SIGNATURE AUTHORIZATION**

**Patient Name (Printed)**

I request that payment of benefits be made to me (on unassigned claims) or on my behalf (on assigned claims) to Cornea Consultants of Arizona for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage or for which my insurance company has paid me. If I have had previous refractive surgery, I understand that this may affect my insurance coverage and I could be responsible for the payment.

I hereby authorize Cornea Consultants of Arizona to release information acquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

I authorize Cornea Consultants of Arizona to leave reminder messages on my answering devices for appointments.

**Date**

**Patient Signature**

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