THE GULF COAST GLAUCOMA CLINIC

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PRIVATE INSURANCE AUTHORIZATION
FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize and direct payment of my medical benefits to
THE GULF COAST GLAUCOMA CLINIC
for any services furnished to me by the physicians. I understand that I am financially responsible for any non-covered services. I also authorize release to my insurance company any information required to process claims of benefits.

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Date Patient (or Responsible Party) Signature

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MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to
THE GULF COAST GLAUCOMA CLINIC
for any services furnished to me by the physicians. 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 theses benefits payable for related services.

_____ _____

Date Patient (or Responsible Party) Signature

FOR OFFICE USE ONLY: Do not write in this area