INSURANCE AUTHORIZATION / PAYMENT AGREEMENT

I authorize payment of medical benefits to Claremore-Pryor Eye Clinic, P.A. for services rendered. I also authorize Claremore-Pryor Eye Clinic, its physicians, employees, and agents to release medical information to insurance companies, third party payers as is necessary for completion of insurance claims, determination of benefits, and related items.

I have read and understand the above information. I understand I am responsible for payment of any insurance deductibles, co-payments, or services and materials not covered by my insurance. My signature on this form will serve as a "Signature On File" for processing claim forms.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to say any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

By Oklahoma law we are required to notify you...**that the information authorized for release may include records which may indicate the presence of a non-communicable or diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

I understand and agree to all policies included in the Notice of Privacy Practice.

Patient Name (please print) _____

Patient Signature (parent if minor) _____ **Date** _____

Primary Insurance Information

Insurance Name _____ Effective Date _____ Tel. # _____

Mailing Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Relationship _____ Birthdate _____

Soc. Sec. Number _____ ID # _____ Group # _____

Secondary Insurance Information

Insurance Name _____ Effective Date _____ Tel. # _____

Mailing Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ Relationship _____ Birthdate _____

Soc. Sec. Number _____ ID # _____ Group # _____

Vision Insurance Information

Insurance Name _____ Soc. Sec. Number _____

Policy Holder's Name _____ Relationship _____ Birthdate _____