

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made to Burrows Vision Clinic for any services furnished me by Dr. Burrows. 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 or the benefits payable for related services.

Our office accepts assignment on eye examination fees for Medicare eligible patients. If you have Medicare Part B coverage we will file any claims for you at no charge. If you have not met your deductible for the year, the charges will be applied to your deductible. You'll receive an explanation of benefits in the mail that will inform you of this amount. You are responsible for any Medicare approved charges not paid by Medicare or your supplement insurance.

SIGNATURE _____ **DATE** _____