2869 N High Street | Columbus, OH 43202 | P: 614.263.2020 | F: 614.725.2279

INSURANCE AUTHORIZATION FORM

I, _____ authorize Eyes on High, LLC to bill my insurance company for myself (or beneficiary/dependents listed below) for any services covered by my insurance. I understand that any copays, deductibles, and fees not covered by my insurance are my financial responsibility. Also, I am responsible for notifying this office of any changes in my insurance plan or coverage.

_____ _____

Patient Signature Date

Patient also signing for beneficiary / dependents listed below:

_____

_____

_____

Updated: 09/2014