SAULT VISION CLINIC P.C.

"SIGNATURE ON FILE" AUTHORIZATION

Statement to Permit Payment of Any Health Insurance
Benefits to Supplier, Physician, or Patient

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.

I understand and agree that any incurred expenses not covered by the insured's health carrier must be paid for at the time of services.

I hereby authorize payment directly to Sault Vision Clinic P.C., for any services rendered to me by any of its authorized agents.

I authorize the release of all medical information to the insured's health insurance carrier that is:

1) acquired in the course of my examination or treatment and

2) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions.

Signed: _____

Date: _____