I hereby authorize this vision care provider to apply for benefits on my behalf for covered services rendered by them. I also assign my benefits and request that all payments from my vision insurance policy be made directly to the vision provider. **I agree to assume responsibility for full payment pending any remaining balance that is not covered by my vision insurance policy.**

I certify that the information I have reported with regard to my coverage is correct. I further authorize this vision care provider to release to my vision insurance provider and its agents any information related to this or any related claim.

_____ _____

Signature Date