SKYVISION™
CENTERS

AUTHORIZATION TO SIGN INSURANCE FORMS

I hereby make, constitute, and appoint SkyVision Centers to execute on my behalf and sign my name on any and all medical health insurance forms relating to medical treatment rendered by SkyVision Centers, including the power to direct payment of any such insurance benefits directly to SkyVision Centers.

I understand that this is a lifetime medical authorization request and that payment of medical benefits be made either to me or to SkyVision Centers on my behalf for any services rendered. I also authorize release to the agency that regulates medical fees and payments, and its agents, any medical information needed to determine the benefits payable for related services.

Unless SkyVision Centers obtains payment directly from my insurance company or any other third party payer program under which I am covered, I am responsible for paying the full amount charged for the services. Should SkyVision Centers receive direct payment, I am still responsible for any deductible or co-payment due.

I also understand that Medicare and other insurance carriers do not cover refraction exams for spectacle prescriptions. If my physician feels I need a new prescription, I understand a refraction needs to be performed and that the fee for this service is my responsibility.

In order to keep the refraction current, the policy is to perform a refraction at least every two (2) years or if there is a change in vision.

By signing this document, I understand this signature is on file and valid. This authorization must be revoked in writing.

Patient Signature: _____ Date: _____

If someone other than the patient is signing this authorization, please state the relationship to the patient and the reason the patient is unable to sign.

Name: _____ Relationship: _____

Signature: _____ Reason: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received or was provided the opportunity to receive a copy of SkyVision Center Notice of Privacy Practices.

Print Name: _____

Patient Signature: _____ Date: _____

If someone other than the patient is signing this authorization, please state the relationship to the patient and the reason the patient is unable to sign.

Name: _____ Relationship: _____

Signature: _____ Reason: _____

Office Use Only:

- ☐ Signed form received.
- ☐ Acknowledgement not obtained
  - ☐ Patient refused
  - ☐ Other: _____

Staff Members Signature: _____ Date: _____