1815 State Street
Watertown, NY 13601
315.788.6070

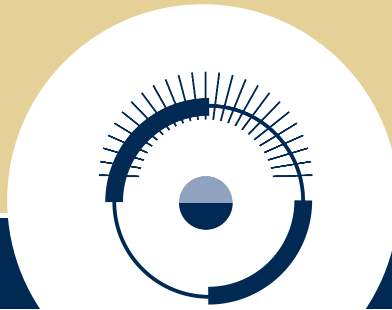
7785 N. State Street
Lowville, NY 13367
315.376.5206

77 W. Barney Street
Gouverneur, NY 13642
315.287.3638

301 Ford Street
Ogdensburg, NY 13669
315.393.7171

LIFETIME SIGNATURE AUTHORIZATION

TOLL FREE: 877-454-EYES



CENTER FOR SIGHT

WATERTOWN EYE CENTER

Patient Name ____

I request that payment under the medical insurance program be made either to me of the provider named above on any bills for the services furnished me during the effective period of this authorization. I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or related Medicare claim, Further permit a copy of this authorization to be used in place of the original. Further, this authorization is to apply to all private insurance claims.

I understand that I am responsible for all financial obligations of health services for the above named patient, and for reimbursement and payment of claims from my insurance company, if for any reason the account should become delinquent. I agree to pay for all rebilling charges, interest charges, collection costs, and reasonable legal fees.

____ ____________________

SIGNATURE DATE