Patient Financial Responsibility

I hereby authorize CDR Eye Associates 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 insurance carrier be made directly to CDR Eye Associates. I agree to assume responsibility of full payment pending any remaining balance that is not covered by my insurance carrier.

I certify that the information I have reported with regard to my coverage is correct. I further authorize CDR Eye Associates to release to my insurance company and its agents any information related to this or any related claim.

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Member's Signature and Date