PATIENT SIGNATURE ON FILE

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Print Beneficiary's Name

I hereby authorize payment of my medical and surgical insurance benefits to Miller Vision Center. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Miller Vision Center. I authorize Miller Vision Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

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Patient's (or Legal Guardian's) Signature and Date