INSURANCE AUTHORIZATION FORM

MEDICARE, MEDICARE SUPPLEMENTS, AND GROUP INSURANCES:

I request that payment of authorized Medicare, Supplement Insurance, or other types of participating insurances be made on my behalf to Douglas R. Weberling, O.D., P.C. for the services furnished for me.

I authorize the release of medical information about me to the Health Care Financing Administration and its Agents for the determination of benefits for these related services.

If for any reason my insurance does not pay my balance, I agree to submit payment for services to Dr. Weberling & Associates.

OTHER INSURANCE

I authorize the release of any medical information to my insurance company to the extent deemed necessary by Douglas R. Weberling, O.D., P.C. to process this and any related claim.

Signature Date