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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of medical or other information necessary to process my medical claim. I authorize payment of Medicare/Medicaid or other health care insurance benefit, paid to Drs. Matoba Optometrists, LLC. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions, and understand that this consent will end when my current treatment plan has been completed, or one year from the date signed below.

Patient's Name:______________________________
(Print)

My Signature:______________________________ Date:______________
(Patient, Parent, or Guardian)

Check One:

_______ I am the Patient

_______ I am the Patient's Parent or Guardian ______________________________
(my name, printed)

01/2019