**Signature on File and Acknowledgement of Receipt**

* I authorize Dr. Holland to use my name on any and all claims or documents that relate to vision insurance benefits due to me and my dependents.
* I authorize release of any information related to any claims to my vision insurance or my medical insurance, if necessary.
* I understand that I am responsible for my bill and agree to pay for all services and items provided to me that are not covered by my insurance company.
* I authorize Dr. Holland to act as my agent in helping me in obtaining payment from my vision and/or medical insurance companies.
* I authorize payment of vision benefits otherwise payable to me, directly to Dr. Holland.
* I permit a copy of this authorization to be used in place of the original.
* This “Signature on File” is valid for one year from the date indicated below
* I acknowledge that I was offered a copy of Irvine Eye Care’s Notice of Privacy Practices

Signature (or Signature of Personal Representative) Date

Print Name Relationship