

Relationship: _____ Phone: _____

By signing below, I am authorizing ProVision Eyecare to act as my agent in helping me obtain payment from my insurance company. This will be used as my signature on file. I authorize payment directly to ProVision. I will also be responsible for any unpaid balances and if further action is needed to collect any debt I will be responsible for all costs incurred:

Signature of Responsible
party: _____ Date: _____