Signature on File

Dubuque Family Eye Care P.C.
3343 Center Grove Drive
Dubuque, IA 52003-5264

_____I understand that I am responsible for my bill.
_____I authorize release of information to all of my insurance carriers
_____I authorize use of this form on all my insurance submission.
_____I understand that I am responsible for any co-pays or overages which may not be covered by my insurance carriers.
_____I authorize payment directly to my doctor.
_____I permit a copy of this authorization to be used in place of the original.

Patient Name_____

Relationship to Guarantor/Responsible Party_____

Signature of Guarantor/ Responsible Party_____Date_____