Signature
OPTOMETRY
EYE CARE FOR YOU

- I authorize Chris Fisher OD Inc. DBA Signature Optometry to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.

- I authorize release of any information related to any claims to all my Insurance Companies or
other relevant parties.

- I authorize payment of health benefits otherwise payable to me, directly to Chris Fisher OD Inc. DBA Signature Optometry.

- I understand I am financially responsible, whether my insurance company pays or not, for all
charges incurred by me. I further agree that in the event of nonpayment, I will bear the cost of
collection and / or court costs and reasonable legal fees should such action be required.

- I understand that if my method of payment is returned unpaid for any reason an additional $25 fee will be added to my account.

- I understand that 48 hours notice is required if I am unable to keep my appointment. Otherwise,
a $25.00 Cancellation Fee will be charged.

- I understand that payment is due at the time services are rendered.

- I permit a copy or digital copy of this authorization to be used in place of the original.

I acknowledge and agree to the above statements on

_____ Sign

_____ Print Name

_____ Date

5430 N Palm Ave Ste 101, Fresno, CA 93704
Phone 559.432.0606 | Fax 559.432.0608

275 S Madera Ave Ste 300, Kerman, CA 93630
Phone 559.846.8210