Carolina Cataract & Laser Center, P.A.

Health Insurance Claim Release and Treatment Authorization Form

Please list your insurance company/companies below:

____ By signing this form, I authorize release of any medical information necessary to process my insurance claims. My signature means that I request Medicare, Medigap or any other insurance company listed above to make payment directly to Dr. Vincent Dahringer at Carolina Cataract & Laser Center, P.A..

____ **Medicare Patients:** The information that we obtain is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made. I authorize the holder of medical information about me to release to Medicare and or its agents the information needed to determine benefits on my behalf. I do understand that Carolina Cataract & Laser Center, P.A. does accept Medicare assignment and that I am responsible for any deductible, co-insurance and non-covered services.

____ **Treatment:** I authorize Dr. Vincent Dahringer to give me treatment according to proper medical care standards.

_____ _____
Sign Date

_____ _____
Sign Date

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Sign Date