

## LA SPECS

### **RELEASE OF INFORMATION, GUARANTEE OF PAYMENT, SIGNATURE FOR FILE:**

I authorize LA SPECS to release to the Social Security Administration, Centers for Medicare & Medicaid Services, its intermediaries or my medical/vision insurance carrier any information needed for a medical/vision claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical/vision insurance benefit either to myself or to LA SPECS.

Insurance companies do not guarantee payment. In the event the services I receive in this office are not covered by my insurance, I understand that I am responsible for all unpaid charges, and further agree to pay any and all costs associated with these fees.

**The HIPAA Privacy Act requires us to keep your medical information private. Please sign acknowledging that you were offered a copy of the HIPAA document/Privacy Policy, and have given your consent for our office to verify, authorize and file insurance claims for your and/or your dependents behalf.**

PRINT NAME OF PATIENT OR RESPONSIBLE PARTY \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_