# BLANKET ASSIGNMENT

I request that payment of authorized medical benefits be made to Advanced Eye Care for any services provided or materials furnished by them. I authorize any holder of insurance information needed to determine my benefits to release information to Advanced Eye Care related to the services provided to me.

I request and authorize Advanced Eye Care on my behalf to inquire about medical benefits, in regard to its payment(s) for charges incurred by Advanced Eye Care. However, in the event that my insurance is unable to provide payment, I agree as the patient to pay for services rendered.

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Patient or Guarantor Signature Date