Optique Boutique

Dr. Paul DiFiore, O.D
Joanna Welsh, O.D.
3223 Route 38, Mt. Laurel NJ 08054
856-234-7881

INSURANCE AUTHORIZATION AND CONSENT SIGNATURE ON FILE

I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.
I authorize release of the information to my insurance carrier(s).
I authorize my doctor in helping me obtain payment from my insurance carrier(s).
I authorize my doctor to provide healthcare information written and/or verbally to my primary physician, other physicians and allied health personnel.

Patient's Name _____ (Please Print)

Primary Insurance Company Name: _____

Policy # _____ Group # _____ Policyholder's Employer _____

Policyholder's Name _____ Relationship to Patient _____ Policyholder's DOB_____

Secondary Insurance Company Name: _____

Policy # _____ Group # _____ Policyholder's Name_____ DOB_____

PATIENT'S SIGNATURE_____ **DATE** _____