FAMILY VISION

518 College Ave., Suite 200
Clemson, SC 29631
(864) 722-9205

2808 E. North Ave.
Anderson, SC 29625
(864) 226-6041

900A Greenville Dr.
Williamston, SC 29697
(864) 847-7657

Signature on File

I authorize use of this form on all of my insurance submissions.

I authorize release of the information to all my insurance companies.

I understand I am responsible for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor.

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

Name: _____

Signature: _____

Date: _____