Patient Name: _____

Social Security#: _____

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

Family Vision Center of Crosby
14700 N. FM 2100 Ste 3
Crosby, Texas 77532

Or

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it to:

Family Vision Center of Crosby
14700 N. FM 2100 Ste 3
Crosby, Texas 77532

A check for the professional or medical expense benefits allowed, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered shall be mailed to Family Vision Center of Crosby**.** THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____:_____ this _____ day of _____, 20_____

_____ _____

Signature of Policy Holder Witness