Mark W. Doubrava, M.D.

Signature Authorization

Patient Name: (print) ____

I request and authorize that payment of insurance benefits be made to Mark W. Doubrava, M.D.

I agree to pay the balance of expenses not paid by my insurance plan after 45 days of claim submission.

I agree to pay all costs not covered by my insurance plan.

I understand that the refraction (measurement for glasses) is not covered by Medicare or some commercial insurances. The refraction is a necessary part of an eye exam. I am responsible for this fee at time of service.

I hereby authorize the office of Mark W. Doubrava, M.D., to release information or medical record acquired during the course of my examination and/or treatment to my referring physician or to any appropriate insurance carrier including The Health Care Financing Administration (HCFA).

This insurance authorization shall remain in effect until I choose to revoke it in writing. Copies of this authorization may serve as the original.

Date: ______________________________

Patient Signature: ____

Mark W. Doubrava, M.D.

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