SACRAMENTO CONTACT LENSES
OPTOMETRY, INC.

SACRAMENTO
701 Howe Ave
Suite G-48
Sacramento Ca. 95825

Roseville
1700 Eureka Road
Suite 180
Roseville Ca. 95661

Name_____Date_____20_____

I authorize Sacramento Contact Lenses & Optometry, Inc. to bill my insurance Company, _____for Services and /or Materials on _____20_____. I am aware that an authorization or notification from my insurance company is not a guaranteed form of Payment. Co-payments and/or covered options may pay differently then designated by the insurance company. In the event that my insurance does not pay the claim I understand I am responsible for the balance.

Signature_____

Relationship to patient if minor_____