



5555 West Loop South, Ste 150
Bellaire, TX 77401
(713) 666-4224 - Fax: (713) 666-4201

Willowbrook Methodist Hospital
18220 Tomball Parkway, Ste 140
Houston, TX 77070
(281) 469-3888 - Fax: (281) 469-4442

AUTHORIZATION TO FILE INSURANCE

PATIENT: _____

INSURED: _____ D.O.B. OF INSURED _____

SS#/ID#: _____ GROUP: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to the following. If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Warren Cross & Associates
5555 West Loop South, Ste 150
Bellaire, TX 77401

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. 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 this insurance payment. A photocopy of this Agreement 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 doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Policyholder

Witness

I understand that if my insurance denies payment for services provided I will be responsible for charges to my account.

Signature of Policyholder

Witness

WAIVER OF LIABILITY AGREEMENT

I understand the physician(s) at Warren Cross & Associates are accepting me as a private pay patient for the duration of my eye care, and **I will be responsible for paying for any services I receive**. If I am enrolled with an insurance company, the provider will not file a claim to my insurance company for services provided to me, nor will I hold the insurance company liable for services provided to me.

Patient Signature: _____ Date: _____

Witness: _____