TOWER CLOCK
EYE CENTER
The difference is in sight.

Patient Signature on File for Medicare Claims

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Tower Clock Eye Center for any services furnished to me by them. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents to help determine these benefits or the benefits payable for related services.

This authorization is in effect until I revoke it.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

If you are a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.