Daniel T. Martinez O.D., Inc.
14319 E. Ramona Blvd. Baldwin Park, CA 91706
Phone# (626) 960-8655 Fax# (626) 960-5996

Responsible Party: _____ **Date:** _____

I hereby authorize this vision care provider to apply for benefits on my behalf for covered services. I also assign my benefits and request that all payment from my **vision care plan** to be made directly to this doctor. I agree to assume responsibility of full payment, pending payment, or any remaining balance that is not covered by my **insurance**. I also agree to pay this provider in case my claim gets denied, even though my benefits have been verified by this office.

30 DAYS ORDER POLICY: You are required to pick up your order (Glasses or Contact Lenses) within 30 days from the date of service. If the order is not picked up during this time frame; you will lose any deposit or total payment made for this order. No refund will be given and no order will be returned to you.

I certify that the information I have reported with regard to my coverage is correct. I further authorize this vision care provider the release to vision care plan and its agents any information related to this or any related claim. I also agree to this office policy.

Signature _____ **Patient's Name:** _____

Member or Tutor if Under 18