VISION SOURCE®
THE WOODLANDS

Assignment of Benefits

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to **Michael R. Gerdts, OD PA dba Vision Source Woodlands** for vision / medical services or items rendered to me or my dependent by **Michael R. Gerdts, OD PA dba Vision Source Woodlands**. Should my insurance carrier deny **Michael R. Gerdts, OD PA dba Vision Source Woodlands**, I understand that I am financially responsible for the charges. I authorize **Michael R. Gerdts, OD PA dba Vision Source Woodlands** to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of vision / medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.