

Donald R. Korb, OD, FAAO
Joan M. Exford, OD, FAAO
Victor M. Finnemore, OD, FAAO
Optometrists



400 Commonwealth Ave. • Unit 2
Boston, MA 02215
(617) 426-0370
Fax: (617) 426-4924

Name _____ DOB ____ / ____ / ____

Address _____

City _____ State _____ Zip code _____ - _____

Phone #s – home _____ work _____ cell _____

Health insurance _____ Vision insurance _____

Subscriber _____ Insurance ID # _____

Patient's relation to subscriber: self spouse child former spouse other

Assignment and Release

I authorize payment of benefits directly to Korb & Associates for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services may require approval of my primary care physician for coverage, and that if I do not obtain that approval, I am financially liable for the services.

I understand that some services and products may not be covered by my insurance carrier, and that benefit information does not constitute approval of payment. Fees not paid by my insurance carrier will be my responsibility.

Signature _____ Date ____ / ____ / ____