Hollingshead Eye Center, P.C.℠

Mark E. Hollingshead, M.D.
Ryan T. Barrett, M.D.
Jason R. Besecker, O.D.
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REQUEST FOR PAYMENT DOCUMENTATION

Please fill out the information and sign below. We will send you your information within 1 week. This information will include payments made to SurgiCare Center of Idaho and LaserCare Center of Idaho.

Dates: _____ thru _____

Patient Name: _____

Date of Birth: _____

- ☐ Fax: _____
- ☐ E-mail: _____
- ☐ Mail: _____ _____ ___ _____
  Street City ST Zip

_____ _____
Signature Date

Thank you,

The Staff at Hollingshead Eye Center