CLEARVIEW EYECARE AND LASER CENTER

ASSIGNMENT OF BENEFITS

Patient Name:_____ DOB:_____-_____-_____ SSN:_____-_____-_____

Address:_____ Phone Number:_____-_____-_____

MEDICARE INSURANCE

I hereby irrevocably assign and transfer to Clearview Eyecare and Laser Center/Clearview Surgery Center all rights and benefits whether contractual or statutory. Photocopy of this original shall be as valid as original. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. In Medicare Assigned cases, the provider agrees to accept the charge determination of the Medicare Carrier and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay and/or any non-covered services. **Please be aware that if you have a refraction for glasses, this is a non-covered procedure and you will be responsible for this charge.** My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

Initials:_____

HEALTH INSURANCE OR MEDIGAP

I hereby irrevocably assign and transfer to Clearview Eyecare and Laser Center/Clearview Surgery Center all rights and benefits whether contractual or statutory. Photocopy of this original shall be as valid as original. I authorize any holder of medical information about me or any information needed to determine the benefits payable for related services to release it to my Medigap insurer or any other insurer. I know that I am responsible for any deductible, co-pay, co-insurance and/or any non-covered procedures. Please be aware that if you have a refraction for glasses, some insurances do not cover this procedure. This is a separate test performed to determine if your vision has changed or can be improved with glasses or contact lens. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Initials:_____

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how medical information may be used and disclosed and how you can get access to this information. By signing this form you are acknowledging that you have been given our Notice of Privacy Practices.

Initials:_____

AUTHORIZATION TO DISCUSS HEALTH INFORMATION

I authorize **CLEARVIEW EYECARE & CLEARVIEW SURGERY CENTER** to discuss my health information with the names listed below:

1)_____ 2)_____

Emergency Contact:

Name:_____ Phone Number:_____
Home Work Cell

Patient Signature:_____ **Date:**_____

Clearview Staff Signature:_____ **Date:**_____