EYE PHYSICIANS AND SURGEONS, L. L. P.
ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITIES

PLEASE PRINT

Patient Name: _____, _____, _____
Last Name First (not nickname) Middle initial
Home Phone: (____) _____ Cell: _____ May we leave a message on machine? ___

Home Address: _____City: _____State:_____ Zip: _____

Birth Date: ___/___/___ Age: ____ Sex: M _ F _ Marital Status: S_ M_D_W_ SS#____/___/_____

Spouse / Parent Full Name: _____ Date of Birth: ____/_____/_____

Emergency Contact Person: _____ Relationship: _____ Ph#: _____

With whom may we discuss your care? _____ Relationship_____

Patient Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ St: ____ Zip: _____

Name of Primary Insurance: _____ Secondary: _____

Referring Doctor: _____ Primary Care Doctor: _____
(if applicable) Drs. Full Name
Preferred Pharmacy: _____ Location: _____

How did you hear about us? Friend/Family ___ Phone Book ___ Newspaper ___ Internet ____ Other _____

1. I understand that I am responsible for charges not covered or reimbursed by my insurance. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

2. I authorize my insurance carrier to release information regarding my coverage to Eye Physicians and Surgeons. I also authorize agents of any hospital, or previous physicians to furnish Eye Physicians and Surgeons copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any physician, optometrist, optician, pharmacy or insurance carrier as needed or requested by me. I also agree to a review of my records for purposes of internal audits, research and quality assurance review within Eye Physicians and Surgeons.

3. My right to payment for all procedures, tests, supplies and nursing/physician services including major medical benefits are hereby assigned to Eye Physicians and Surgeons. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Eye Physicians and Surgeons.

THIS AGREEMENT / CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read the above statements and accept the terms.
Patient signature: _____ Date: _____
OR
Parent/Responsible Party Signature: _____ Date: _____

Updated: _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____
Initials: _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____