ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or any other information to the Center for Medicare and Medicaid Services, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by the JOHN-KENYON AMERICAN EYE INSTITUTE. A copy of this authorization will be sent to the Center for Medicare and Medicaid Services, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by the JOHN-KENYON AMERICAN EYE INSTITUTE.

FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to the JOHN-KENYON AMERICAN EYE INSTITUTE and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify the JOHN-KENYON AMERICAN EYE INSTITUTE of any changes in my health care coverage. In some cases exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the JOHN-KENYON AMERICAN EYE INSTITUTE and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

I understand if my insurance requires a referral, I am responsible for obtaining the referral.

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, Medigap, and/or other secondary insurances to the JOHN-KENYON AMERICAN EYE INSTITUTE for all covered medical services and supplies provided to me during all courses of treatment and care provided by the JOHN-KENYON AMERICAN EYE INSTITUTE and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as I am being treated or cared for by the JOHN-KENYON AMERICAN EYE INSTITUTE, and will constitute a continuing authorization, maintained on file with the JOHN-KENYON AMERICAN EYE INSTITUTE, which will authorize and allow for direct payment to the JOHN-KENYON AMERICAN EYE INSTITUTE of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by the JOHN-KENYON AMERICAN EYE INSTITUTE.

_____

Patient/Insured (Printed Name)

_____ _____

Patient/Insured (Signature) Date