ACADEMY EYE ASSOCIATES INSURANCE POLICY

PATIENT NAME _____ DATE _____

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize Academy Eye Associates to release any of my medical health information necessary to process any insurance claims on my behalf.

I authorize Academy Eye Associates to release any of my medical health information to other medical health care practitioners to whom I may be referred to for further medical evaluation.

ASSIGNMENT OF BENEFITS

I authorize payments of insurance related medical or vision benefits to Academy Eye Associates.

OFFICE POLICY ON ALL INSURANCE

You must provide your insurance information at the time of your visit for Academye Eye Associates to file your claim. Otherwise you will be required to file the claim yourself. We only accept assignment on insurance plans for which we are providers. All co-payments are due at the time of service.

If your plan offers discounts on materials, all charges must be paid at the time of the order. If you find that you have insurance AFTER your visit, we are not able to adjust fees to reflect any difference in the payment schedule of your insurance plan.

Your signature is kept on file acknowledging our policy regarding insurance and authorizes us to file insurance claims on your behalf.

Please understand that you are ultimately responsible for paying for all services and materials irrespective of insurance benefits.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Date _____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____

Print Name _____

Signature _____