Regional Eye

Insurance Consent

I have requested medical services from Regional Eye Specialists on behalf of myself and/or my dependents. I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

Regional Eye Specialists will submit claims to your insurance company if current information is provided with a copy of the insurance card(s). **If your insurance requires a referral or prior authorization and you did not call your primary care clinic, you will be responsible for all charges billed to you.** Services not covered by insurance may be paid with check, cash or credit card.

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled. I authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health plan to issue payment directly to Regional Eye Specialists, P.A. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize Regional Eye Specialists to (1) release any information necessary to insurance carriers regarding my office visit and (2) process insurance claims generated in the course of examination or treatment.

This assignment will remain until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

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Patient Name (Please Print)

_____ _____

Signature of Patient/ Responsible Party Date