INSURANCE INFORMATION

SUBSCRIBER: ______________________________ RELATIONSHIP TO PATIENT: _______________

SUBSCRIBER'S D.O.B.:____________ EMPLOYER: ____

INSURANCE COMPANY: ____

POLICY #: __________________ GROUP #: _______________________ SS#: ____________________

☐ **ASSIGNMENT AND RELEASE** (See Next Section for Medicare)

I, the undersigned certify that I (or my dependent) have insurance coverage with the Insurance company listed above, and assign directly to **Village Eye Associates, LLC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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Signature of Responsible Party Date

☐ **MEDICARE AUTHORIZATION** (Only for Medicare Patients)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Village Eye Associates, LLC** for any services furnished me by that doctor. 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 or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

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Signature of Beneficiary Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA

I acknowledge that I am aware of the ***Notice of Privacy Practices*** in the office of **Village Eye Associates, LLC** and if desired I can receive a copy for my records upon request.

PATIENT NAME: ____

(Please Print)

SIGNATURE: ____ **DATE**: ________________

(Parent or Guardian of under 18)