AUTHORIZATION

INFO RELEASE ~ ASSISGNMENT OF BENEFITS ~ FINANCIAL LIABILITY

PRIMARY INS: _____

SUBSCRIBERS NAME: _____

SUBSCRIBERS BIRTDATE: _____ SS_____-_____-_____

RELATION TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN

SECONDARY INS: _____

SUBSCRIBERS NAME: _____

SUBSCRIBERS BIRTDATE: _____ SS_____-_____-_____

RELATION TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN

I request that payment of authorized MEDICARE ~ MEDIGAP ~ MEDICAID ~ PRIVATE or COMMERCIAL INSURANCE benefits be made on my behalf to MP EYECARE CENTER, PA or any PHYSICIAN of that group. I authorize MP EYECARE CENTER, PA to release to my insurance company any information needed to determine benefits payable for related services. This assignment shall remain in effect until revoked upon my written request. A photocopy of this assignment is considered as valid as the original.

I AM AWARE THAT A CLAIM FILED ON MY BEHALF IS SUBJECT TO MY INSURANCE DEDUCTIBLE, CO-PAYMENTS AND CO-INSURANCE.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

_____ _____

SIGNATURE DATE