mt. pleasant EYE CARE CENTER, P.A.
BRIAN K. NICHOLS, O.D.
903-572-1991
www.mpeyecare.com

AUTHORIZATION, INFORMATION RELEASE, ASSIGNMENT OF BENEFITS FINANCIAL LIABILITY

MEDICAL INSURANCE _____ _____

Policy Holder Name_____ _____

Date of Birth _____/_____/_____ SS#_____-_____-_____
MM DD YYYY

Relation to Patient: Self ☐ Spouse ☐ PARENT ☐ GUARDIAN ☐

VISION INSURANCE _____

Policy Holder Name _____ _____

Date of Birth _____/_____/_____ SS#_____-_____-_____
MM DD YYYY

Relation to Patient: Self ☐ Spouse ☐ PARENT ☐ GUARDIAN ☐

Authorization, Information Release and Assignment of Benefits:

I request that payment of Medicare/Private or Commercial Insurance benefits be made on my behalf to Mt. Pleasant Eye Care Center, P.A. or any physician of that group.

I authorize Mt. Pleasant Eye Care Center, P.A., 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.

Financial Liability:

I am aware that a claim filed on my behalf is subject to my insurance deductible, copay and coinsurance. These amounts will be billed directly to me if applicable.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Vision Coverage / Medical Coverage:

During the performance of a ***Comprehensive Eye Examination***, certain medical eye conditions may be revealed that deserve special attention.

I understand that ***there are specific coverage limitations with my Vision Care Plan***. The Mt. Pleasant Eye Care Center, P.A., contract with the Vision Care Plan ***does not cover medical eye care services***. In this event, my **MEDICAL PLAN** will be billed. I understand I will be responsible for any applicable copays, cost-shares, and/or deductibles.

I also understand that Mt. Pleasant Eye Care Center, P.A., will not neglect medical findings and bill my vision plan, as that would put Mt. Pleasant Eye Care Center, P.A., in direct conflict with its ethical obligations to the State Board of Optometry.

SIGNATURE_____ DATE _____
PATIENT OR PARENT OR GUARDIAN