ASSIGNMENT OF BENEFITS

Patient name:______________________________Medicare Beneficiary #______________________

I hereby irrevocably assign and transfer to Lehmann Eye Center/Doctors Surgery Center/Clearview Laser Center all rights and benefits whether contractual or statutory. Photocopy of this original shall be as valid as original. 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 payable for related services. In Medicare Assigned cases, the provider agrees to accept the charge determination of the Medicare Carrier and **I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay and/or any non-covered services. Please be aware that if you have a refraction for glasses, this is a non-covered procedure and you will be responsible for this charge.**

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

MEDIGAP OR OTHER INSURANCE

I hereby irrevocably assign and transfer to Lehmann Eye Center/Doctors Surgery Center/Clearview Laser Center all rights and benefits whether contractual or statutory. Photocopy of this original shall be as valid as original. I authorize any holder of medical information about me or any information needed to determine the benefits payable for related services to release it to my Medigap insurer or any other insurer. **I know that I am responsible for any deductible, co-pay, co-insurance and/or any non-covered procedures.**

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

Signature_______________________________________Date_______________

Witness____Date_______________

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how medical information may be used and disclosed and how you can get access to this information. By signing this form you are acknowledging that you have been given our Notice of Privacy Practices.

Signature____Date____________________

Witness____Date____________________

LEHMANN EYE CENTER/DOCTORS SURGERY CENTER