ASSIGNMENT OF BENEFITS
LEHMANN EYE CENTER/DOCTORS SURGERY CENTER

Patient Name: _____ Date of Birth: _____

Patient Account Number: _____

I hereby irrevocably assign and transfer to Lehmann Eye Center/Doctor 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 portion 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/Doctor 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 I am responsible for any deductible, co-pay, co-insurance, any non-covered procedures, and/or any non-covered diagnostic testing.**

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

Patient Signature: _____

Witness Signature: _____

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.

Patient Signature: _____

Witness Signature: _____

Lehmann Eye Center / Doctor's Surgery Center may contact me by using the phone, fax, email, and other communication methods available. I am approving the ability of the center to leave a detailed message if no answer. If I want to exclude or edit any of these communication options I am listing ones to exclude on the line below.

Excluded methods: ☐ Phone ☐ Mail ☐ Email ☐ Fax

Lehmann Eye Center / Doctor's Surgery Center
5300 North Street
Nacogdoches, TX 75965
(936)569-8278 Phone (936)-569-0275 fax

Patient Name: _____

DOB: _____

I authorize and request the release and ability to pick up all information regarding my Medical history, Billing history, Diagnosis, Care, Treatment, or progress while under the care of Lehmann Eye Center or Doctor's Surgery Center to the Following:

Name:

_____
_____
_____

This authorization is valid until changed in writing and verified received by the center and does not expire until I am no longer under the care of the center. I understand that I have the right to revoke this authorization in writing anytime. My Care and/or Treatment cannot be conditioned on the signing of this authorization. I also have the right to receive a copy of this authorization and that a photocopy may be considered valid.

By signing below I authorize the release of any and all protected health information to the above named person(s). I understand that information released may contain private information related to mental/behavioral health issues, sexually transmitted diseases, AIDS, HIV and other private diagnoses.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date: _____