INSURANCE INFORMATION

Name of person responsible for this account _____
Relationship to patient _____ Date of Birth _____ SS# _____
Insurance Company_____ Group #_____
Is patient covered by any additional or supplemental insurance? □ YES □ NO

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **DANVILLE EYE CENTER, PLLC** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I financially responsible for all charges whether or not paid for by insurance**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature _____ Date _____

FOR OUR MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made on my behalf to **DANVILLE EYE CENTER, PLLC** for services furnished me by this provider. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine those benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim.

I have been notified by **DANVILLE EYE CENTER, PLLC** that some of my services may be non-covered by Medicare. I agree and understand that I am personally and fully responsible for these services today. Medicare has notified us that the following services are **not covered**; the $25.00 refractive portion of your eye exam, eyeglasses or contacts (unless you have just had cataract removal and IOL implants) and any medications from our office.

RELEASE OF INFORMATION

I authorize **DANVILLE EYE CENTER, PLLC** to release or to discuss any information they deem necessary to another health care provider.

By signing below I have read, understand and agree with the above statements.

Responsible party signature _____ Date _____