RIDGWAY EYECARE CENTER P.C.

ASSIGNMENT OF BENEFITS & PRIVACY PRACTICES

ASSIGNMENT OF BENEFITS

I hereby assign all medical and vision benefits to which I am entitled to Ridgway Eyecare Center PC. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health plan, to issue payment checks directly to Ridgway Eyecare Center PC for eye care services rendered to myself and/or my dependents. I understand that should legal action be required to collect my bill I will be responsible for attorneys fees and court costs.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Ridgway Eyecare Center PC to (1) release information necessary to insurance carriers regarding my treatments, (2) process insurance claims generated in the course of examination or treatment, and (3) allow a photocopy of my signature to be used to process insurance claims for the period or a lifetime. This order will remain in effect until revoked by me in writing.

I have requested services from Ridgway Eyecare Center PC on behalf of myself and/or my dependents, and understand that by making this request I become fully responsible for any and all charges incurred.

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have received, and had the opportunity to review the Notice of Privacy Practices. I understand this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a copy.

I UNDERSTAND IT IS MY RESPONSIBILITY TO KEEP ALL PATIENT INFORMATION SUCH AS, PHONE NUMBER, ADDRESS, INSURANCE CARRIER/ POLICY NUMBERS, AND PRIMARY CARE PHYSICIAN UP TO DATE WITH RIDGWAY EYECARE CENTER PC.

Patient Name _____ **Birth Date**_____

Patient /Responsible Party Signature_____

Date_____ **Phone Number**_____

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