Hartzell Eye Specialists, LLC *featuring Optical Allusions*

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David Leigh Hartzell, MD
Ophthalmologist

INSURANCE
Financial Responsibility
Assignment of Benefits
Authorization to Release Information

Financial Responsibility
I have requested ophthalmology/optician services from Hartzell Eye Specialists on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that all professional services rendered are charged to the patient and are due at the time of service, UNLESS other arrangements have been made in advance with our business office which includes the completion of necessary forms in order to file with insurance and full disclosure of deductible information.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits
I hereby assign all ophthalmology/optician benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Hartzell Eye Specialists for ophthalmology/optician services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information to Insurance Company
I hereby authorize Hartzell Eye Specialists to: (1) release any information necessary to insurance carriers regarding my treatment; (2) process insurance claims generated in the course of evaluation and/or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of covered care. This authorization will remain in effect until revoked by me in writing.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Date

c: patient
forms/fin respons-assign of bene-roi