Specialty EyeCare Center

Lourdes Lorino, O.D.
Doctor of Optometry

STATEMENT OF FINANCIAL RESPONSIBILITY

1. PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION
I hereby authorize and direct payment of my benefits to **Specialty EyeCare Center**, for any services furnished to me by the physician(s). I authorize the physician to release any information, including diagnosis and the records of any treatment or examination rendered to me during the period of such medical services to third party payers and/or health practitioners. In the event that my health plan determines a service to be "not covered," I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed.

2. AUTHORIZATION OF PAYMENTS
I understand that as a courtesy, **Specialty EyeCare Center** may assist me in verifying my benefits and submitting my claim(s) to my insurance carrier. I hereby authorize payment directly to **Specialty EyeCare Center** and its physician(s) of benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for any insurance co-pay, deductibles, co-insurances and non-covered services.

3. MEDICARE LIFETIME SIGNATURE ON FILE
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Specialty **EyeCare Center** for any services furnished me by the physician(s). I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determination these benefits or the benefits payable for related services.

4. MEDIGAP AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION
I request that payment of authorized Medigap benefits be made either to me on my behalf to **Specialty EyeCare Center** for any services furnished to me by the provider of service. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits payable for related services.

5. CONSENT OF TREATMENT
I hereby authorize **Specialty EyeCare Center**, through it's appropriate personnel, to perform or have performed upon me, or the patient I am responsible for, appropriate assessment, tests and/or treatment.

6. INSURANCE DISCLAIMER
You are responsible to notify **Specialty EyeCare Center** of your current insurance information and to provide the necessary information about your insurance plan; therefore, please have your current insurance card with you at all times, as well as a photo ID such as a driver's license, military ID or government issued ID.

_____
Patient Name (Please Print)

_____
Signature of Patient (or Responsible Party) Date

11/07

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Sé Habla Español