Suncoast Eye Center Eye Surgery Institute

AUTHORIZATION and ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by the **Suncoast Eye Center-Eye Surgery Institute.** I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services.

I hereby authorize the **Suncoast Eye Center-Eye Surgery Institute** to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my Insurance Carrier(s) Medicare to make payment directly to **Suncoast Eye Center-Eye Surgery Institute** for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Patient Signature: ________________________________ ***Date:*** ____________________

PATIENT PRIVACY QUESTIONNAIRE

Please list the family members or significant others, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment and health care operations) and in Case of an Emergency.

1. Name: ____________________________________ Relationship________________________

   Phone Number: ______________________________ DOB: ______________________________

   Name: ____________________________________ Relationship________________________

   Phone Number: ______________________________ DOB: ______________________________

2. Can we send any Appointment Reminders, Lab Results and/or Correspondence from our office to the address you listed as your home address? ***YES*** ______ ***NO*** _______

I have received a copy of the **Suncoast Eye Center-Eye Surgery Institute's** office **Privacy Notice** as required by HIPAA.

Patient Signature: ____ (Guardian if under 18 years)

Patient Name: (Print) _____________________________________ Date: ___________________________

Witness: ____ Relationship: ____________________