FINANCIAL & INSURANCE AUTHORIZATIONS

THE NON-MEDICARE PATIENT

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or vision benefits, including major medical benefits in which I am entitled, to Dr. Conn. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that some insurance plans do not cover the "refraction," a separate part of an eye exam. If the "refraction" is not covered, I agree to assume responsibility for this charge.

I understand that insurance is filed as a courtesy and that verification of benefits is no guarantee of payment. I understand it is my responsibility to verify information provided to Dr. Conn and to make sure that he is an eligible provider on my plan. I will be responsible for any unpaid amounts.

SIGNATURE_____ **DATE**_____

THE MEDICARE PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Conn for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that Medicare will not pay for routine services. I understand that I will be financially responsible for charges not covered by Medicare such as refraction, CPT 92015.

I also request payment of authorized Medigap benefits be made either to me or on my behalf to Dr. Conn for any services furnished to me. I authorize the release of medical information needed to determine these benefits.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

SIGNATURE_____ **DATE**_____