KEARNEY EYE SURGICAL CENTER

RELEASE OF INFORMATION, FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

Release of Information

I agree that Kearney Eye Surgical Center may disclose my protected health information to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices, or my employer. I hereby authorize release of all medical information necessary for treatment to all healthcare providers involved in my care. A photocopy of this assignment is as valid as an original, and revocable by me only in writing. I hereby authorize said assignees to release all information to secure payment.

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, including major medical benefits, Medicare, private and group insurance, or other health care plan, to Kearney Eye Surgical Center. I authorize direct payment to the facility of any insurance benefit. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Financial Responsibility and/or Agreement

I agree to pay the facility in accordance with its regular rates and terms. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account. Should collection become necessary, I agree to pay any additional collection fees, and legal fees including attorney fees, court costs and filing fees.

By signing this document, I agree to the terms listed above.

_____ _____

Patient or Representative Signature Date

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Witness Signature with Title

patient label