Assignment of Benefits/Authorization to Release Information/Privacy Policy Acknowledgement

I assign directly to Roby Eyecare Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, including any service that my insurance deems non-covered or not medically necessary, all coinsurance/copayment amounts, all deductibles, any amount above the benefit limitations on my policy and any amount not covered because I was not insured at the time of service.

I authorize the use of my signature on all insurance submissions.

I authorize the disclosure of my health care information to my insurance company and its agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

I acknowledge having received a copy of Roby Eyecare Associates Privacy Policy.

____ ______________

Patient or Responsible Party Signature Date

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Patient's Printed Name

If signed by a Responsible Party, please complete the following:

____

Responsible Party Printed Name

____

Address

Relationship to Patient: ____________________________