Insurance Assignment & Release

IC Laser Eye Care

I certify that I have insurance coverage with _____ _____ (name of insurance company) and assign my benefits directly to **IC Laser Eye Care** and **Doctors** affiliated for any services rendered. I understand that I am financially responsible for all charges not paid by insurance. I authorize the use of my signature on all submissions. The above named office and doctors affiliated with this office may use my health information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits and benefits payable for the related services. This consent will end when my current treatment plan is completed.

Print Name:_____Date:_____

Signature of Patient, Parent or Guardian:_____

Medicare/Medigap Authorization

I request that payment of authorized Medicare Benefits and, if applicable, Medigap benefits be made to the above office and its doctors for any services furnished to me by this provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the center for Medicare and Medicare Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefit related services.

Print Name:_____Date:_____
Signature of Patient, Parent or Guardian:_____

Treatment Consent

I hereby consent and give permission to the Doctor and Doctor's Assistant to administer and preform such procedures upon me as the Doctor deems necessary.

Print Name:_____Date:_____
Signature of Patient, Parent or Guardian:_____

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