

Elmore County Eyecare: Drs. Price & Gibbons

Patient Name: _____	Date of Birth: _____
Address: _____	SSN: _____
Phone Number: _____	

Insurance Information

Primary Insurance Holder : _____
SSN: _____
Date Of Birth: _____

Assignment & Release

I, the undersigned, certify that I (or my dependant) have insurance with

And assign directly to Elmore County Eyecare 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. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all submissions.

Signature: _____	Date: _____
Signature: _____	Date: _____
Signature: _____	Date: _____
Signature: _____	Date: _____
Signature: _____	Date: _____
Signature: _____	Date: _____

IF YOU ARE COVERED BY MEDICARE, PLEASE READ AND SIGN BELOW

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Elmore County Eyecare for any services furnished by my Doctors associated with the same. 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 my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charged determination of the Medicare Carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary

Date