PALM BEACH EYE CENTER

ASSIGNMENT OF BENEFITS

I, the undersigned, state that I (or my dependent) have/has insurance coverage with the insurance carrier(s) whose identification cards I have presented to this office. I assign all insurance benefits directly to Palm Beach Eye Center, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by my insurance carrier, as well as all attorneys' fees should they be deemed necessary to collect on this financial obligation. I authorize the use of this signature on all insurance submissions.

Signature **Date**

RELEASE OF INFORMATION

I, the undersigned, hereby authorize this office to release all information, medical or otherwise, necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and/or correspondence.

Signature **Date**

MEDIGAP AUTHORIZATION (MEDICARE SUPPLEMENT)

I, the undersigned, state that I (or my dependent) have/has insurance coverage with the Medigap or Medicare supplemental insurance carrier(s) whose identification card(s) I have presented to this office. I assign all insurance benefits directly to Palm Beach Eye Center, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature **Date**

RELEASE OF LIABILITY

I understand that medication in the form of eye drops will be placed in my eyes during my eye examination. One of the eye drops is an anesthetic and the others are to dilate my pupils. I understand that I can have an allergic reaction to the drops and that dilating the pupil in very rare instances could trigger a sudden rise in eye pressure (acute angle closure glaucoma) which, if not treated promptly could lead to irreversible loss of vision.

I understand that having my pupils dilated will blur my vision, especially at near, and make my eyes sensitive to light. These effects should last for only a few hours. During the time my pupils are dilated, if I drive or operate machinery, I am responsible for any bodily harm it may cause.

Signature **Date**

PATIENT NAME (Please Print)