OCULOPLASTIC ASSOCIATES OF TEXAS

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY CERTIFY THAT THE INFORMATION IS CORRECT AND THAT I HAVE NO OTHER COVERAGE OTHER THAN THAT WHICH IS LISTED ON MY PERSONAL INFORMATION FORM.

I am giving Oculoplastic Associates of Texas permission to ask for payments from Medicare and/or my insurance company(s) for my care. I understand that Medicare and/or my insurance company(s) need information about me and my medical condition to make a decision about these payments. I give permission for that information to be forwarded to Medicare and/or my insurance company(s). I request that payment of authorized benefits be made to Oculoplastic Associates of Texas. I further authorize any holder of medical information about me to release to Medicare and/or my insurance company(s) any information needed to determine these benefits or the benefits payable for related services.

ERX CONSENT

I agree that Oculoplastic Associates of Texas may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

AUTHORIZATION FOR PATIENT PHOTOGRAPHY

I hereby authorize Oculoplastic Associates of Texas to photograph the ophthalmic condition for which I am seeking care. I understand these photographs are often necessary for documentation of medical conditions and are needed by the insurance companies for verification or to be used for teaching purposes. We will make a charge for these services to cover the cost of film and developing the photographs. Most insurance companies recognize the necessity of performing this service and will usually cover the expense.

HIPAA

I acknowledge that the Notice of Privacy Right (HIPAA) has been made available for my review and I give Oculoplastic Associates of Texas my permission to use and disclose my health information in accordance with it.

Initials: _____

Please list any person, if any, whom we may inform about your general medical condition and diagnosis (including treatment, payment, and healthcare operation):

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Can confidential messages be sent to your voicemail or email? Yes_____ No_____

_____ _____

Signature of Patient or Guardian **Print Name of Patient**

_____ _____

Patient's Date of Birth **Date of Signature**