Niagara Eye Associates & Niagara Optical

1801 West 8th Street - Erie, PA 16505 * Telephone: (814) 455-8004 Fax: (814) 456-6054

Please read and check the box to show that you understand and agree with our policies.

❑ Insurance Authorization

I have Insurance Coverage with _____ and assign directly to Niagara Eye Associates and Niagara Optical all medical 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 the insurance. I hereby authorize the doctor to release al information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Policy Holder/Guarantor Information:

Policy Holder's Name: _____ Date of Birth: _____/____/_____
Relation to Patient: _____ SSN: _____
Policy Holder's Address: _____Phone: _____
Policy Holder's Employer: _____

❑ Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Niagara Eye Associates and Niagara Optical for any services furnished m by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HFCA 1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurance agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurances and the deductible are based upon the charge determination of the Medicare carrier.

❑ Disclose Information

I authorize Niagara Eye Associates and Niagara Optical to disclose this health information to the following individual(s) only

Name: _____ Phone: _____ Relationship: _____

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❑ HIPAA PRIVACY POLICIES

This notice authorizes Niagara Eye Associates and Niagara Optical to use and disclose health information for treatment, payment, and healthcare operations regarding the care of the patient. We reserve the right to change our notice of privacy practices to make the terms of any change effective for all protected health information that we maintain, including the information created or obtained prior to the date of the effective date of change. I have received the "Notice of Privacy Practices" for Niagara Eye Associates and Niagara Optical and Niagara Eye Associates and Niagara Optical are authorized to use and disclose health information on my behalf

I have read and agree to the terms listed above.

Signature_____ Date _____