Insurance Authorization and Assignment of Benefits

Release of Medical Information Authorization

I authorize Gutshall & Kohle Eyecare to release pertinent information about my medical condition for the purpose of securing health insurance benefits, information, authorization or payment. I will provide a current copy of any insurance identification cards, policy numbers, photo identification and demographic information upon request. I also authorize Gutshall & Kohle Eyecare to act as my representative and on my behalf to secure all authorization necessary from my insurance company regarding procedures or orders. I understand that I may revoke this authorization at any time by giving a statement in writing to withhold my personal and medical information from that time forward.

Assignment of Benefits.

I request that payment of authorized insurance benefits be made on my behalf to Gutshall & Kohle Eyecare. I understand and agree that a copy of this authorization and/or assignment of benefits, when signed by me, my authorized representative, or a legal guardian, may be sent to my insurance company or health care provider, if requested. A copy of this authorization and assignment of benefits shall be as valid as an original, and Gutshall & Kohle Eyecare may refer to my signature on file regarding this authorization and/or this assignment of benefits.

By my signature, or an authorized signature, below, I understand and agree to the following:

- I am financially responsible for any charges not covered by my health care benefits and for any portion of any charges denied by my health care benefits, in accordance with applicable law;
- I am responsible to notify Gutshall & Kohle Eyecare of any changes in my address and in my health care coverage, and failure to do so may result in delays in processing my claim and/or order or inability to process my claim and/or order;
- In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim and this may delay the processing of my claim;
- Since I am assigning to Gutshall & Kohle Eyecare my right to receive payment directly from my insurance company or from Medicare or Medicaid, if I receive payment directly, I agree to reimburse fully upon request for the cost of my services and/or order(s) and I understand that Gutshall & Kohle Eyecare has the right to recover its cost of collection from me if I fail to reimburse them properly and timely, in this circumstance;
- I acknowledge receiving or viewing a copy of Gutshall & Kohle Eyecare Notice of Privacy Practices;
- I understand that Gutshall & Kohle Eyecare will endeavor to obtain authorization from my insurance provider to reimburse for services or items that may be covered. However, there is no guarantee that Gutshall & Kohle Eyecare will receive authorization or payment from my insurance provider.

By signing below, I hereby certify that the information I have provided in this form is truthful, correct, and complete, and I understand and agree to the terms of this authorization and assignment of benefits. I acknowledge that any inaccurate information provided in this form or omission of accurate information may delay the processing of my claim and/or my order.

Name (Please Print): _____

Signature: _____

Relationship to Patient: _____ Date: _____