ILLINOIS eye
CENTER
Your Vision Empowered

Medical Benefits Authorization

Patient Name: _____

Acct. No.: _____ **Patient Date of Birth**: _____

I request that payment of authorized medical benefits be made either to me or on my behalf to the Physicians of Illinois Eye Center for any services provided to me by these physicians. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am financially responsible for any and all charges not covered by my insurance, Medicare, Medicaid, or other third party payers, including deductibles, co-pays and/or coinsurance amounts. Most medical insurance plans, including Medicare, do not cover Refraction fees. Our office policy is to charge for this procedure in addition to the office visit co-pay and/or deductible. I agree to pay my account regardless of such coverage. If Illinois Eye Center has to take additional steps to collect this account, I agree to pay all costs of collection including court costs and reasonable attorney fees.

I agree that Illinois Eye Center may request and use my prescription medication and durable medical equipment from third-party pharmacy benefit payers; and exchange electronic health record history with other healthcare providers. I may opt out of electronic health record sharing at any time by notifying the front desk staff.

Illinois Eye Center notice of privacy practices provides information about how we may use and disclose protected health information. The Illinois Eye Center is in compliance with the Health Insurance Portability and Accountability Act of 1996. I acknowledge that I have received a copy of the Illinois Eye Center notice of privacy practices. I give my permission for medical information to be sent to me by phone, mail, or e-mail.

By signing below, you are authorizing us to call you at any number you provide, including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for incoming calls from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Signature_____

Date_____