RETINA HEALTH INSTITUTE S.C.
Vision Redefined
1530 N Randall Road, Suite 202, Elgin, IL, 60123
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www.retinahealthinstitute.com

BENEFITS ASSIGNMENT

Last Name	First Name	DOB
Address		SSN

AUTHORIZATION FOR MEDICAL INFORMATION RELEASE - I authorize Retina Health Institute, S.C. to release to my insurance company, any medical information needed to determine benefits payable for related services.

AGREEMENT OF RESPONSIBILITY – I understand that professional services are rendered and charged to the patient. CO-PAY IS DUE AT THE TIME OF SERVICE (Co-insurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance, as well as attorney fees and costs to Retina Health Institute, S.C. if this matter is referred to collection.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS – I authorize use of this form for release of information needed to process claims to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping obtain payment from my insurance companies. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive monthly statements for any balance due by me. I also understand, full payment is required to be made on receipt of your 1st statement after insurance has met their obligation.

MEDICARE AUTHORIZATION – I request payment of authorized Medicare benefits be made on my behalf to Retina Health Institute, S.C., for any services provided to me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents, any information needed to determine these benefits or benefits payable for related services.

I understand my signature requests payment to be made and authorize release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes release of information to insurer or agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge of determination of the Medicare carrier as the full charge – the patient is responsible for deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

MEDIGAP/SUPPLEMENTAL AUTHORIZATION - I request payment of authorized Medigap/Supplemental benefits on my behalf to Retina Health Institute, S.C., for any services furnished me by that physician/supplier. I authorize holder of my medical information to release to Medigap/Supplemental and its agents, any information needed to determine these benefits or the benefits payable to related services.

AUTHORIZATION – INSURANCE/FINANCIAL MATTERS - By my signature, I also authorize Retina Health Institute, S.C., to discuss financial/insurance matters on my behalf with those persons designated below (Please PRINT complete names & relationship):

PATIENT: DATE: