BROST & Associates FAMILY EYE CARE, P.C.

Kyle E. Brost, O.D. ♦ Meredith E. McLeod, O.D.

ASSIGNMENT OF BENEFITS

Patient : _____ **DOB:** _____

Assignment of Benefits:

"I hereby authorize *Brost & Associates Family Eye Care, P.C.* to release any medical or other information necessary to process claims for services incurred under their care. I assign direct payment to the physician all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at the time of service and the information is not corrected prior to my insurance company's timely filing limit. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization shall be as valid as the original."

_____ _____

Patient/Representative Signature *Date*

Medicare Assignment of Benefits *(MEDICARE PATIENTS ONLY)*:

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Brost & Associates Family Eye Care, P.C.* for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services."

_____ _____

Patient/Representative Signature *Date*