

# Eye Plastic Surgery Associates

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## **Assignment of Benefit**

I authorize payment of medical benefits to Eye Plastic Surgery Associates for services rendered.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

## **Release of Information**

I authorize the release of any medical information necessary to process claims for payment of services rendered from Eye Plastic Surgery Associates. I also request insurance benefits to be paid to Eye Plastic Surgery Associates.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

## **Signature on File (MEDICARE PATIENTS ONLY)**

I request that payment of authorized Medicare benefits be made either to me on my behalf or to EYE PLASTIC SURGERY ASSOCIATES for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable. I understand my signature requests that payments be made and authorizes the release of medical information necessary to pay the claim if item 9 of the HCFA 1500 claim form is completed. In Medicare assigned cases, Eye plastic Surgery Associates agrees to accept Medicare assignment, and the patient is responsible only for the Medicare deductibles, coinsurance, and non-covered services.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date