INSURANCE AUTHORIZATIONS
SIGNATURE ON FILE

FOR OUR MEDICARE PATIENT/ABN WAIVER

I request payment of authorized Medicare benefits be made either to me or on my behalf to Drs. Morrill and Diamond for any covered services furnished to me. 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 or the benefits payable for related services.

I understand Medicare will not cover any services determined as routine/screening. I understand I will fully and personally financially be responsible for these charges. These services included refraction, routine eye exams, glasses and contact lenses and services (with the exception of glasses after cataract surgery in most cases), no-line, progressive and transition lenses, non medically necessary tints, scratch coatings, other additional patient options for glasses, contact lenses solutions and/or cleaners. Other non-covered services by the Medicare program include low vision examinations and low vision aids. In addition, unless I am QMB-Medicare/Medicaid recipient, I understand I will be financially responsible for any non-covered items under the Medicaid/TennCare program.

MEDICARE/MEDIGAP BENEFITS

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Drs. Morrill and Diamond for any services furnished to me. I authorize any holder of medical information about me to release to my Medigap insurance carrier any information needed to determine these benefits or the benefits payable for related services.

These assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signed: _____ Date:_____
(Patient of Guarantor)

OUR NON–MEDICARE PATIENT/ACCEPT ASSIGNMENT

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all vision, medical and/or post operative surgical benefits including major medical benefits to which I am entitled to Drs. Morrill and Diamond. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand I will be financially responsible for non-covered services and charges.

Signed: _____ Date:_____
(Patient of Guarantor)