ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____
NAME OF INSURANCE COMPANY(IES)

Assign directly to LeGrand Associates insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.
I authorize the use of my signature on all claim submission(s).
The above named Ocularist and/or Facility Representative may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

This consent will end when my current treatment plan is completed or one year from date signed below

_____
SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

_____
PRINT NAME OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

_____ _____
DATE RELATIONSHIP TO PATIENT

MEDICARE/MEDIGAP AUTHORIZATION

*FOR PATIENTS WHO HAVE MEDICARE AND/OR MEDIGAP

I request that payment of authorized Medicare Benefits and if applicable Medigap Benefits, be made to either me or on my behalf to _____ of LeGrand Associates for any services
NAME OF OCULARIST
furnished to me by that provider.

To the extent permitted by law, I authorize any holderof medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related service.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____
Print name of Beneficiary, Guardian or Personal Representative