



THE EYE MD

9010 Lorton Station Blvd, Suite 250
Lorton, VA 22079
571-285-2020

Assignment of Benefits

INSURANCE

I hereby authorize Potomac Eye Consultants to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or, in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). A copy of the authorization may be used in place of the original. **This authorization may be revoked by either me or my insurance carrier at any time in writing.**

Initials

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Potomac Eye Consultants for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. **I understand and agree that I am financially responsible for charges not paid by my insurance company.**

Initials

APPOINTMENT POLICY

If you are unable to keep a scheduled office visit appointment, we ask that you give us at least 24 hours notice. "No Shows" may be charged a \$35.00 fee.

Patient (or Guardian) Signature

Date

Patient Name (printed)

Date of Birth