KUMAR EYE
INSTITUTE

# Assignment of Benefits/Release of Medical Information

I hereby authorize and request that payment of benefits by my primary insurance company and my secondary insurance company (if any) be made directly to Kentucky Eye Surgery Associates PSC DBA Kumar Eye Institute for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Kumar Eye Institute to disclose any and all written information from my insurance company and/or its designated representatives, at the determination of Kumar Eye Institute . Such disclosure shall be for reimbursement purposes for those services received.

I hereby release Kumar Eye Institute, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above named insurance company(s) or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
2. I agree to participate and assist Kumar Eye Institute or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at anytime except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. Kumar Eye Institute is acting in filing for insurance benefits assigned to Kumar Eye Institute and it can assume no responsibility for guaranteeing payment of any changes from the insurance company(s).
6. A firm contracted by Kumar Eye Institute for billing and collection purposes may do billing.
7. Kumar Eye Institute is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
8. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
9. Kumar Eye Institute shall be entitled to the full amount of its charges without offset.
10. I have the right to refuse any procedure or treatment.
11. I have the right to discuss all medical treatments with my provider.

Patient Name: _____

Patient Signature: _____

Date: _____.