COLLINS EYE CLINIC
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FOR ALL INSURANCES & SELF-PAY PATIENTS.
PATIENT OR LEGAL GUARDIAN MUST SIGN THIS ACKNOLEDGEMENT IN ORDER TO RECEIVE TREATMENT.

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE COLLINS EYE CLINIC TO FURNISH ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THIS ORIGINAL.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS:

I HEREBY ASSIGN TO COLLINS EYE CLINIC ALL INSURANCE PAYMENTS OTHERWISE PAYABLE TO ME FOR SERVICES FROM TIME TO TIME, BUT NOT TO EXCEED MY INDEBTEDNESS TO COLLINS EYE CLINIC. IT IS UNDERSTOOD THAT ANY MONEY RECEIVED FROM THE INSURANCE COMPANY(S) OVER AND AVBOVE MY INDEBTEDNESS TO COLLINS EYE CLINIC WILL BE RETURNED TO ME WHEN MY BILL IS PAID IN FULL.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBLILITY:

I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR PAYMENT OF SERVICES AND IN CASE OF DEFAULT, I MAY BE RESPONSIBLE FOR REASONABLE ATTORNEY'S FEES AND ALL COSTS OF COLLECTIONS TO INCLUDE COLLECTION FEES AND LATE FEES.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO COLLINS EYE CLINIC FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT. I ATTEST TO THE FACT THAT I HAVE READ ALL OF THE ABOVE STATEMENTS AND FULLY UNDERSTAND IT'S MEANING.

SIGNATURE:_____DATE:_____