DOCTORS
SEHY AND JONES
Optometrists
MEMBER Vision Source NETWORK

MEDICARE/MEDIGAP

I request that payment of authorized Medicare Benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Doctors Sehy and Jones, Optometrists for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to be released 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 services.

_____

Signature of Beneficiary, Guardian or Personal Representative Date

_____

Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary

AUTHORIZATION OF BENEFITS

I authorize Drs. Sehy and Jones, Optometrists to release any information; including diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such eye case to third party payors and/or health practitioners.

Drs. Sehy and Jones Optometrists requires copies of your insurance cards to file your insurance. If you have any type of vision plan that provides discounts, this must be presented at the time of your visit to receive these discounts.

I authorize and request my insurance company to pay directly to Drs. Sehy and Jones benefits otherwise payable to me. I understand that my insurance carrier may pay less than those charges submitted. I agree to be held responsible for payment of all services rendered on my behalf or my dependents. I understand that amounts not paid are subject to further action; such as referral to a collection agency, and may include a $25.00 collection Fee.

Name of Insurance Company (s) _____

Signature of Patient or Responsible Party _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT (HIPPA)

I ACKNOWLEDGE THAT I RECEIVED A COPY OF DRS. SEHY AND JONES OPTOMETRISTS NOTICE OF PRIVACY PRACTICES.

DATE: _____

PATIENT NAME: _____ SIGNATURE _____