LIFETIME AUTHORIZATION OF INSURANCE BENEFITS

By signing below, I request that payment of insurance benefits be made on my behalf to Craig Blackwell MD for any services furnished me by their physicians/suppliers. I understand that my signature requests that payment be made and authorizes the release of any medical information necessary to ensure payment.

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made on my behalf to Craig Blackwell MD for any services furnished me. I authorize holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information need to determine these benefits or the benefits payable for related services. I further understand that Craig Blackwell MD has agreed to accept the allowed charge determined by Medicare as the full charge. Medicare pays 80% of that charge, and I understand that I am responsible for the balance of the charge, deductibles, co-insurance and non-covered services. Co-Insurance and deductibles are determined by the carrier. I understand that Medicare excludes all refractive services (checking my glasses prescription) from their coverage. I agree to be personally and fully responsible for the refractive portion of my exam. Medicare (and most other insurances) does not cover eyeglasses or medications in most cases. If other health insurance coverage is indicated (secondary insurance), my signature authorizes payment of benefits to Craig Blackwell MD and release of medical information necessary to process that claim to that insurer or agency.

HMO/PRIOR AUTHORIZATION PATIENTS: I understand that I am ultimately responsible for authorizations for care/treatment to be provided by Craig Blackwell MD. If for ANY reason a service is not authorized or is denied, I assume full responsibility for any and all charges, including co-payments and deductibles.

PRIVATE PAY PATIENTS – Payment for services rendered is expected at the time of service. We offer a discount for payment at the time services are provided (optical materials excluded).

I have read the above information. I understand that all charges for services rendered are ultimately my responsibility. Should Craig Blackwell MD not be a contracted provider, or if the services rendered are not a covered benefit under my plan, I am responsible for all charges related to the services provided me and will pay in full for such charges.

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PATIENT (RESPONSIBLE PARTY) SIGNATURE DATE

A copy of this form will be provided to you at your request.