

CONSENT TO MEDICAL TREATMENT AND ASSIGNMENT OF BENEFITS

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS TO MUNSTER EYE CARE ASSOCIATES, P.C.

I, the undersigned, being the person whose name appears hereafter designated as the "patient" or being a person legally authorized to consent to services on behalf of the patient, do hereby voluntarily consent and authorize Munster Eye Care Associates, P.C. and its agents to administer any treatment which may be deemed necessary and advisable for the diagnosis and treatment of the patient including: medical care, surgical care, diagnostic tests, procedures, drugs and other services that may be advisable for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by Munster Eye Care Associates P.C., nor have I relied upon any such representations, warranties, or guarantees.

I hereby assign directly to Munster Eye Care Associates P.C payment of any health insurance benefits, including but not limited to any and all applicable Medicare benefits, applicable to this treatment and authorize the release of information necessary to determine coverage and to permit reimbursement on my behalf to Munster Eye Care Associates P.C. Regardless of my insurance benefits, I understand I am financially responsible for the fees for services rendered and all collection and attorney fees, if applicable. If I choose not to have my insurance claims submitted on my behalf, or if I am without insurance benefits applicable to today's services, I understand and agree that I am financially responsible for the fees for services rendered by Munster Eye Care Associates P.C and all collection and attorney fees, if applicable. These fees for services are payable at the time services are rendered.

Patient (parent/guardian) Signature

Insurance Identification Number

Relationship to Patient

Date

MEDIGAP/SUPPLEMENT BENEFITS

I, the undersigned, being the person whose name appears hereafter designated as the "patient" or being a person legally authorized to consent to services on behalf of the patient, do hereby voluntarily consent and authorize Munster Eye Care Associates, P.C. and its agents to administer any treatment which may be deemed necessary and advisable for the diagnosis and treatment of the patient including: medical care, surgical care, diagnostic tests, procedures, drugs and other services that may be advisable for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by Munster Eye Care Associates P.C., nor have I relied upon any such representations, warranties, or guarantees.

I request that payment of authorized Medigap benefits be made either to me or assigned on my behalf to Munster Eye Care Associates P.C for any services furnished to me by Munster Eye Care Associates P.C. I authorize any holder of medical information about me to be released to (Name of Medigap Insurer) _____ any information needed to determine these or the benefits payable for related services. Regardless of my insurance benefits, I understand I am financially responsible for the fees for services rendered by Munster Eye Care Associates P.C and all collection and attorney fees, if applicable.

Patient (parent/guardian) Signature

Medigap Number

Relationship to Patient

Date