

## **ASSIGNMENT OF BENEFITS/AUTHORIZATION**

I hereby assign payment directly to Carolina Ophthalmology of the surgical and or/major medical benefits, if any, otherwise payable to me for the professional services rendered in the course of any examination of treatment. This authorization shall remain valid until revoked in writing.

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Signature (Insured)

Date

## **RESPONSIBILITY FOR PAYMENT OF MEDICAL SERVICES**

I understand that Carolina Ophthalmology will file my insurance as a courtesy. However, I am ultimately responsible for all medical fees relating to my care. Should my insurance deny for any such reasons as; an authorization, deductible, or non-covered service, I understand that I will be responsible for my bill.

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Signature: Patient or Responsible Party if Patient is a Minor

Date

## **NOTICE OF PRIVACY PRACTICES**

I understand that Carolina Ophthalmology's Notice of Privacy Practices informs me of how my medical information may be used pertaining to treatment, payment and healthcare operations. My signature signifies that I have received a copy of this notice.

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Signature: Patient or Responsible Party if Patient is a Minor

Date

In order to better serve our patients, their families and comply with federal government's privacy act, we ask that you list below who you give Carolina Ophthalmology permission to discuss your medical information with:

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Name

Relationship

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Name

Relationship

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Name

Relationship

If at any time you decide to add/remove anyone from this list you will need to contact us in writing or in person.