EYE PLASTIC SURGERY ASSOCIATES

David H. Saunders, M.D., F.A.C.S.
Mark L. Mazow, M.D., F.A.C.S.

Please initial each line and sign at the bottom.

Patient Name: _____ Account Number: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION:

_____ I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, including claims for disability benefits, insurance applications and prescriptions. I authorize transmission of medical information by USPS and fax.

SIGNATURE ON FILE/ASSIGNMENT OF BENEFITS:

_____ I authorize my insurance company to make payment of my medical benefits directly to Eye Plastic Surgery Associates for covered services rendered. In Medicare assigned cases, Eye Plastic Surgery Associates agrees to accept Medicare assignment. The patient is responsible for all co-payments, deductibles, co-insurances, as well as all services deemed non-covered by the insurance company. Please refer to the Financial Policy for additional information

.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

_____ I have received a copy to review or am aware of the Notice of Privacy Practices. This is a standard policy from HIPAA requiring the protection of your personal information commonly referred to as PHI or Protected Health Information. Should you want a copy of the policy for your records, please notify a staff member.

HIPAA AUTHORIZATION:

_____ I hereby authorize the staff of Eye Plastic Surgery Associates to communicate with the following persons regarding my care:

NAME	RELATIONSHIP	PHONE NUMBER

_____ _____

Patient/Guardian Signature Date