ASSIGNMENT OF BENEFITS

Please Read and Sign

I request the payment of authorized Medicare or other insurance company benefits, including Medigap, be made on behalf of me or my dependent(s) to Eye Physicians of Northampton for any services furnished. Regulations pertaining to Medicare assignment of benefits apply. Eye Physicians of Northampton accepts Medicare Part B assignment.

I authorize Eye Physicians of Northampton to release medical or other information pertaining to me or my dependent(s) to insurance carriers for related Medicare or other insurance company claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. I understand that it is mandatory to notify the health care provider or any other party who may be responsible for paying for me or my dependent(s) treatment. I agree to pay all fees and charges for such treatment. I agree that I will not withhold or delay payments if Medicare or other insurance companies deny payment on any of my or my dependent(s) charges.

Signature_____ Date_____