Eye Clinic of Meridian, PLLC

Don E. Marascalco, M.D.
Diplomate, American Board of Ophthalmology

Cassie N. Confait, M.D
Board Eligible, American Board of Ophthalmology

J. Lawrence Mason, Jr., M.D.
Diplomate, American Board of Ophthalmology

Eric J. Johnson, II, O.D
Certified Therapeutic Optometry

Eye Clinic of Meridian • Butler Eye Center • Livingston Eye Center

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER OR PHYSICIAN

PATIENT NAME _____

I request that payment of authorized Medicare benefits be made on my behalf to THE EYE CLINIC'S providers for services furnished me by either physician (DON E. MARASCALCO, M.D., J. LAWRENCE MASON, JR., M.D., CASSIE N. CONFAIT, M.D., ERIC J. JOHNSON, II, O.D.). I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE _____ Date Signed _____

STATEMENT TO PERMIT PAYMENT OF PRIVATE/GROUP INSURANCE, MEDICAID, MEDIGAP, OR SUPPLEMENTAL INSURANCE OR ANY OTHER INSURANCE BENEFITS TO PROVIDER OR PHYSICIAN.

PATIENT NAME _____

I request that payment of authorized Medicaid, Medigap, or any other supplemental insurance benefits be made on my behalf to THE EYE CLINIC'S providers for services furnished me by either physician (DON E. MARASCALCO, M.D., J. LAWRENCE MASON, JR., M.D., CASSIE N. CONFAIT, M.D., ERIC J. JOHNSON, II, O.D.). I authorize THE EYE CLINIC'S providers to release Medicaid, Medigap, or any other insurance carrier, any medical or other information about me needed for payment of medical insurance benefits. I request that payments of benefits be made to the party accepting assignment.

I certify that the information given by me in applying for payment is correct.

SIGNATURE _____ Date Signed _____

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birth date _____

Signature _____ Date Signed _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff of the Eye Clinic of Meridian, PLLC to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the notice of privacy Practices of Eye Clinic of Meridian, PLLC.

Name and relationship of person who you wish to allow access – for example, your spouse, sibling, neighbor, care-taker, close friend:

Name of Person or Entity	**Phone #**	**Relationship**

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or, if the purpose of the disclosure is related to research, at the end of the research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Eye Clinic of Meridian, PLLC and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization in writing, at any time by sending such a written notification to the practice's Privacy Contact. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure if the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) If my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority