# ALLEN C. RICHMOND, MD., P.C.

**Allen C. Richmond, M.D.**
**Diplomat-American Board of Ophthalmology**
**Comprehensive Eye Care and Ophthalmic Surgery**

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## SIGNATURE ON FILE
## INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

____________________ ____________________

(Name of Patient) (Policy I.D. Number)

"I request that payment of authorized insurance benefits be made either to me or on my behalf to Allen C. Richmond MD PC for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent and/or my insurance carrier and its agents, any information needed to determine these benefits payable to related services."

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

X ____________________ ____________________

(Patient's Signature) (Date)

## FINANCIAL RESPONSIBLILTY SIGNATURE

Receipt or use of this information above does not guarantee payment of any health care claim by your insurance company and such information is subject to change even retroactively at anytime. Therefore, you as the patient are responsible for the payment of all services.

X ____________________ ____________________

(Patient's Signature) (Date)