RELEASE AND ASSIGNMENT

ASSIGNMENTS OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I understand I am financially responsible for the unpaid balance in the event that my medical insurance does not pay this account in full. I hereby assign and transfer any insurance benefits due me for services provided by Las Vegas Eye Institute to be paid directly to them.

SIGNATURE DATE

SIGNATURE ON FILE - MEDICARE

I request that payments of authorized Medicare benefits be made on my behalf to Las Vegas Eye Institute for any services furnished to me by Las Vegas Eye Institute. I authorize 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 payable to related services.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the issuer or agency shown.

Las Vegas Eye Institute agrees to accept the charge determination of the Medicare carrier, Blue Cross Blue Shield of North Dakota, as the full charge, and the patient is responsible only for the deductible, coninsurance and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE DATE