SALUS UNIVERSITY
The Eye Institute

Patient Name: _____

MRN: _____

Assignment of Benefits

I request that payment of authorized benefits be made on my behalf to The Eye Institute/Salus University for any services furnished the patient listed above by The Eye Institute/Salus University's physicians and health care providers, and I assign my right to receive these payments to Eye Institute/Salus University. I authorize Eye Institute/Salus University to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my Health Insurance Plan will not direct payment to Eye Institute/Salus University, I agree to forward to Eye Institute/Salus University all health insurance payments, which I receive for the services rendered by Eye Institute/Salus University and its health care providers.

I authorize Eye Institute/Salus University or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

_____	_____	_____
Patient/Person Legally Responsible	Relationship to Patient	Date

Other Health Insurance

I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.

_____	_____	_____
Patient/Person Legally Responsible	Relationship to Patient	Date

Patient Responsibility

I acknowledge that I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. These charges include co-payments, co-insurance, deductibles and services not covered by my health plan or insurance. To the extent no coverage exists under my Health Insurance Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by insurance. I further agree that, if permissible by law, I will reimburse Eye Institute/Salus University for all costs, expenses and attorney's fees that may be incurred by Eye Institute/Salus University to collect those charges.

_____	_____	_____
Patient/Person Legally Responsible	Relationship to Patient	Date