# ASSIGNMENT AND RELEASE

**Patient's Name** _____

I certify that I (or my dependent) have insurance with _____ and assign directly to Dr. David A. Klibanoff, Dr. Benjamin D. Klibanoff/Klibanoff Eye Associates, Ltd., all insurance benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges whether or not paid by the insurance.* I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

# PATIENT'S MEDICARE AUTHORIZATION

**Patient's Medicare Number** _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to David A. Klibanoff, Benjamin D. Klibanoff, Klibanoff Eye Associates, Ltd. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or the 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" 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 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 noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

(Signature of Beneficiary/Responsible Party)

_____

(Date)