Nicolette L. Zawilinski, O.D
2435 Plantation Center Dr, Ste #120 | Matthews, NC 28105
PH: 704-246-7681 | Fax: 704-246-6802|
www.luxeyecare.com

AUTHORIZATION AND ASSIGNMENT

I, _____, authorize LUX Eye Care to take any and all actions necessary to obtain payment from my insurance company, the Social Security Administration or other responsible party for any and all services provided to me by the doctor and staff of LUX Eye Care.

Further, I assign any and all payments due from my insurance company, the Social Security Administration or other responsible party directly to this office. I realize that in the event that my insurance company or other responsible party erroneously sends payments owed to LUX Eye Care directly to me, those payments legally belong to LUX Eye Care. I realize that I must forward those payments immediately to LUX Eye Care.

I understand that my signature below allows LUX Eye Care to release my confidential medical record to the insurance company, The Social Security Administration or other responsible party, in order to expedite payment of my claims.

I further understand that any co-pays or deductible amounts not paid by my insurance company, The Social Security Administration, or other responsible parties, do become my responsibility. In addition, I understand that I am fully responsible for any costs associated with that collection process.

I further understand that if after my claim has been submitted to my insurance company, Social Security Administration, or other responsible party, and it is then determined that I am not eligible; I am responsible for immediately paying the complete balance due. This authorization is effective for all appointments at LUX Eye Care.

HIPPA PRIVACY POLICY

By signing this acknowledgment of Receipt of Notice of Privacy Practices, I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I understand that LUX Eye Care may use and disclose necessary personal health information to another party to permit us to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by LUX Eye Care.

I can be assured that LUX Eye Care does not sell my personal health information to a third party for said party's own use. I acknowledge and agree that LUX Eye Care may submit my vision benefit claims to my health plan to receive reimbursement directly for the vision services and products that I have received.

Patient Signature _____ Date _____ Print Name _____