6656 Germantown Avenue Suite 1
Philadelphia, Pa 19119
Phone: 215-842-5939   Fax:215-842-5937

Assignment of Benefits form/Hipaa Acknowledgement

Financial Responsibility:

I Hereby request that payment of authorized third party insurance benefits be made directly to Nostalgic Eye Care Inc for any services and/or supplies furnished to me by that provider.

I understand that I am financially responsible for any co-payments, deductibles, and non-covered services.

I further acknowledge that any benefits inadvertently paid directly to me/beneficiary for services provided by Nostalgic Eye Care Inc will be endorsed and mailed directly to nostalgic Eye Care Inc within 10 days of receipt.

Medical Records Release authorization:

I hereby authorize Nostalgic Eye Care Inc to furnish and/or release any necessary information to insurance claims in relations to diagnosis and treatment of beneficiary.

I acknowledge that a photocopy of my signature will be used indefinitely to process any insurance claims made by Nostalgic Eye Care Inc until this permission is revoked by beneficiary in writing.

A photocopy of this assignment form is to be considered as valid as the original. A copy of these policies.

Hipaa Policy:

I acknowledge that I have read and understand the privacy policies set forth by Nostalgic Eye Care Inc and that I am able to request and receive a copy of these policies.

Patient Name: _______________________________________ Date: _________________________

Guardian Name: ____ Relationship: _____________________

Patient/Responsible party signature: ____