Vision Forward Association

Assignment of Insurance:

- I hereby authorize Vision Forward Association to release any medical information necessary for the processing of my claims to my insurance carrier.
- I understand this information could include evaluations, daily treatment notes, a discharge summary, and history and physical findings.
- I authorize direct payment to Vision Forward Association of any insurance benefit and or settlement for expenses incurred at this office which would otherwise be payable to myself.
- I understand that I am financially responsible for any charges not covered by my insurance and or settlement of my claim**. I understand that a trial frame refraction (92015- $50.00) may not be covered by my insurance and I may be billed for this charge or be asked to make this payment up front.** I also understand that specialty items (occluders, prisms, foils, etc.) and specialty fittings may not be covered by insurance and I will be responsible for these charges.
- I understand that if I owe a deductible, co-insurance or copayment at the time of service, I will pay it to the Vision Forward Association. Copayments may be collected prior to rendering services.
- I affirm that I have provided the Vision Forward Association with any and all of my insurance coverage information. I understand that if I withhold any insurance information, which would prevent Vision Forward Association from billing any of my insurance carriers properly, those charges would be my responsibility. I understand that Vision Forward will make every effort to provide me with accurate information regarding my financial obligation for services; however, if there is any conflict between the information provided and the coverage for my plan, I will be responsible for these charges.

MEDICARE PATIENTS: I authorize any holder of medical or other information about me to be released to the social security administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply. **I understand that I will be responsible for therapy service charges, if provided during an active home health coverage period.**

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Signature of Client (or Power of Attorney) (Date)