Assignment of Benefits

____
Name of Patient

I request that payment of authorized insurance benefits (including Medicare benefits) be made on my behalf to Vision Source for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for 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, my signature authorizes releasing information to the insurer. Vision Source accepts the charge determination of the Medicare carrier as the full charge, and I'm responsible for the deductible, co-insurance and non-covered services. I understand co-pays and all fees not covered by insurance are due at time of service.

________________________________	______________________
Patient's Signature	Date

NOTICE OF PRIVACY PRACTICES

We are sensitive to the fact that your medical information is private and we have taken steps to protect the privacy of your health information. We are obligated by law to give you notice of our privacy practices. The notice describes how we protect your health information and what rights you have regarding it.

I acknowledge that I received a copy of Notice of Privacy Practices for Vision Source of Wenatchee and Leavenworth Vision Source in Leavenworth.

________________________________	______________________
Patient's Signature	Date