Toms River Eye Associates, P.C.
Optometric Physicians
Advanced Eye Care
And Contact Lenses

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

1. Please be aware that if you have **NOT** met your Medicare deductible for **2018**, you will receive an additional bill from our office (unless the balance is covered by a secondary insurance). This deductible is **YOUR** responsibility.

2. I authorize Toms River Eye Associates, P.C. and their authorized employees, agents and medical providers to release my medical information to insurance carriers, governmental agencies and other entities or individuals charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me, to be paid directly to Toms River Eye Associates, P.C. I consent to having any monies received by the provider of services on behalf to be applied to my outstanding account. I assume full responsibility for payment of any charges for the medical services provided.

Signature:____

Date:____