ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO THE DOCTOR, FOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name: _____

Employer: _____

Claim/Group: _____

SS# or ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check, made out to and mailed to:

Jay L. Schwartz, D.O., P.C.
8416 E Shea Blvd., Suite C-101
Scottsdale, AZ 85260

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. I have agreed to pay, in a current manner, any balance of said professional service charge(s) over and above this insurance payment if elective.

INSURED MEMBER DIRECT PAYMENT NOTIFICATION

If you are an insured member and your health care <facility/provider> is contracting with your health plan, the following guidelines apply:

1.) You may not be required to pay the health care <facility/provider> directly for the services covered by your plan, except for cost-share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductible amounts.
2.) Your provider's agreement with your health plan may prevent the health care <facility/provider> from billing you for the difference between the <facility/provider's> billed charges and the amount allowed by your health plan for covered services.
3.) If you pay directly for a health care service, your health care <facility/provider> is not responsible for submitting claim documentation to your health plan. Before paying your claim, your health plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your plan.
4.) If you do not pay directly for a health care service, your health care <facility/provider> may be responsible for submitting claim documentation to your health plan for the heath care service.

The Determination of Refractive State may not be covered by insurance. The fee for the Determination of Refractive State in order to provide a written prescription is $50.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Your signature below acknowledges that you received this notice before paying Jay L. Schwartz, D.O., P.C. directly for a health care service.

Date: _____

_____ _____
Signature Witness

_____
Signature of Responsible Party