The Vision Store

160 S Camino Del Pueblo
Bernalillo, NM 87004
505-771-3937

# Assignment of Benefits Form

**Please complete all information**

Date _____ Patient _____

Insurance_____/ID_____Grp #_____

Insurance_____/ID_____Grp #_____

I (Your Name) _____, Understand that services rendered to me by Dr. Deidra Casaus are my financial responsibility and that the provider will bill the insurance company(ies) name listed above as a courtesy. I authorize my insurance company to pay my benefits directly to Dr. Deidra Casaus and I understand that I will be fully responsible for any outstanding balance on my account.

I agree to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by the insurance company(ies) named above. I understand that my medical insurance may be billed if something medical is discovered and discussed with the Doctor.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I give permission to Dr. Casaus or staff to call or have a telehealth session for any follow up questions regarding my ocular health if needed.

I also understand that should my insurance company send payment to me, I will forward the payment to Dr. Deidra Casaus within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process: I will be responsible for any cost incurred by the office to retrieve their monies.

I authorize the provider to initiate a complaint to the insurance commissioner for non payments or delays in insurance payment on my behalf and personally will be active in the resolution of claims delay or unjustified reductions or denials.

Patient Name: _____ Signature: _____

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Parent/Guardian Printed Name