Insurance Assignment

The Glen Ellyn Vision Center agrees to accept assignment on your insurance claim. After we receive a claim response, you will be responsible for any unmet deductible, co-payment amounts, and/or denial of benefits. Insurance coverage may or may not reimburse the amount due, according to your policy guidelines. If your medical insurance carrier pays you directly for services which Glen Ellyn Vision Center has submitted and has not been paid for by you, you will be responsible for forwarding that payment to our office.

If you do not present a current insurance card at the time of service, we cannot accept assignment. You will be required to pay for any/all services provided. We will provide you with the information necessary to submit on your own for any reimbursement.

I request that payment of authorized medical insurance benefits be made on my behalf to Glen Ellyn Vision Center. I also authorize the release of any medical information necessary to process claims. I permit my signature to be kept on file for future claims.

Regarding Medicare:

The Glen Ellyn Vision Center participates in the Medicare program. As a participant, we agree to accept assignment on every Medicare claim. After we receive a claim response from Medicare, you will be responsible for any unmet Medicare deductible and/or co-insurance amounts.

Contact Lens Prescriptions

I have been made aware that if I have a contact lens prescription, it will be made available to me through my patient portal.

HIPAA/Privacy Practices

I acknowledge that I have received a copy of the Glen Ellyn Vision Center's Notice of Privacy Practices.

Authorization for Release of Information to Family Members

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. HIPAA privacy laws restrict sharing patient information without the patient's written consent. If you wish to allow your medical or billing information to be shared with family members, please indicate with whom this information can be shared and sign below.

I, _____ / _____
(Print Patient / Responsible Party Name) (If Minor, Print Patient Name)

authorize the Glen Ellyn Vision Center to release my medical and/or billing information to the following individual(s):

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

I understand that I have the right to revoke this authorization at any time (in writing) and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

Signature: _____ Date: _____