

RUSSELL CHAMBLESS, O.D. and ASSOCIATES

3353 MERCER UNIVERSITY DRIVE

MACON, GEORGIA 31204

PHONE: 478-745-2037

PATIENT FINANCIAL AUTHORIZATION AND RELEASE FORM

Patient information regarding billing:

I hereby acknowledge that I am receiving or about to receive health care services

I understand that payment for the services rendered is my sole responsibility

I understand that if Dr. Chambless is out of the network for my particular insurance carrier, I will be responsible for full payment at the time of service

I understand that I am responsible for any co-payments

I hereby authorize Russell Chambless O.D. and Associates to

Bill my insurance provider and receive payment directly for all services rendered on my behalf

Bill me for any amounts not paid by my insurance provider. These include but are not limited to deductibles, and non-covered services. I understand that these are determined by my insurance provider and policy, and agree to be responsible for all resulting balances.

Bill me directly for any services denied by my insurance provider for pre-existing conditions

Bill me directly for any services not paid within 45 days from the date of service

Accepting Assignment:

I understand that Russell Chambless O.D. and Associates will accept assignment for all covered services provided. Assignment is defined as "Reasonable and Customary Charge" for covered services. These are established by the insurance provider for the geographical area in which the service is provided.

Liability Release:

I authorize access to all of my insurance information and medical records necessary to billing the related health care services. I hereby give my permission to release any medical information or insurance information in order to file any insurance claims. I release Russell Chambless O.D. and Associates and its agents from any liability claims or damages that may arise from the disclosure of such information and pursuit of payment. I also assign any benefits paid on my or my dependants' insurance to be paid directly to the provider and payments for services in my or my dependants' behalf are my sole responsibility.

I acknowledge that I have:

Read and understand the above information, my responsibilities and I have access to a copy of this form upon request.

Received at this visit, or a previous, Russell Chambless, O.D. and Associates Notice of Privacy Practices and Patient Bill of Rights

Print Patient Name: _____

If a representative is signing for the patient, list relationship and print name below:

Relationship to patient

Print name

Signature of patient or responsible representative: _____

Date: _____

Time: _____