

## Austin Eye Clinic

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### Direct Assignment of Benefits and Insurance Information

Patient Name: \_\_\_\_\_

Name and Date of Birth of Policy Holder: \_\_\_\_\_

Employer of Policy Holder: \_\_\_\_\_

Name of Primary Insurance: \_\_\_\_\_

Name of Secondary Insurance: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ insurance company to pay by check made out and mailed to Austin Eye Clinic. If my current policy prohibits direct payment, it shall be made out to me and mailed to Austin Eye Clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of medical or other information necessary to process my claim. I authorize Austin Eye Clinic to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness