AUTHORIZATION TO FILE/REFILE/COLLECT FROM INSURANCE

I authorize Dr. Kosek/Dr. Walsh to release to my Insurance carriers. Including Medicare, any information required to file or resubmit my claim. I further authorize all Insurance companies including Medicare Supplements to pay Dr. Kosek/Dr. Walsh directly on my behalf. I authorize all Insurance carriers, Medicare, Medicaid, and Medicare Supplements to provide any information required to resubmit any denied or incorrectly paid claims. I agree to pay the amount for applicable co-payments and materials

This authorization remains in effect until withdrawn by me.

Signature _____ Date _____

AUTHORIZATION TO DISCUSS YOUR INFORMATION WITH FAMILY OR CAREGIVERS

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including your family, children, caregivers, etc... By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person(s) listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time by you.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Leon J. Kosek, O.D.,
Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____