

**MEDICAL RELEASE**

The undersigned authorizes the release of any medical information necessary to process this claim to the insurance companies listed previously. Additionally, the undersigned authorizes the release of any medical record information from other health care facilities to Peter Ming-Tao Ho, M.D.

**ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT**

The undersigned agrees to (1) pay in full at the time of services, (2) present insurance information for the filing of claims, or (3) honor a payment agreement plan until the balance is paid in full. The undersigned further understands that the office will submit itemized statements to the insurance companies as a courtesy to the patients and that by his/her signature, the insurance companies are authorized to make the payment directly to the physician. The undersigned, however, does accept the ultimate responsibility for payment.

**PRIVACY NOTICE**

\_\_\_\_\_ I have received the HIPPA privacy notice for this practice  
Please Initial

**REFRACTION POLICY**

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle. It is an essential part of an eye examination, but it is NOT a covered benefit by Medicare or most insurances. Our office fee for a refraction is \$40.00, and is collected in addition to the patient's copay.

**ACKNOWLEDGMENT**

**I HAVE READ AND UNDERSTAND THE ABOVE RELEASE AND ASSIGNMENT OF BENEFITS.**

Patient's (or Guardian's if a minor)  
Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

Lubbock Ophthalmology Associates, P.A.  
Peter M. Ho, M.D.  
3702 34th St.  
Lubbock, TX 79410  
(806) 799-3944

MEDICAL RECORDS RELEASE

TO: \_\_\_\_\_ DATE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FROM:

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_

I voluntarily request that my medical records be released from your office to  
Lubbock Eye Clinic.

\_\_\_\_\_  
Signature of Patient