Eye Clinics of South Texas. P.A.
WAIVER OF LIABILITY

Medicare/Medicaid/Other Insurance

I understand that, in the opinion of Eye Clinics of South Texas, P.A. (Jay M. Rubin, M.D.) the services or items, that I have requested to be provided to me on the date below, may not be covered under Medicare, Medicaid, or other insurance programs as being reasonable and medically necessary for my care. I understand that Medicare\Medicaid/ other insurance companies determine the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care. By signing below, I hereby authorize the offices of Eye Clinics of South Texas, P.A. (Jay M. Rubin, M.D.) to release all information requested to Medicare/Medicaid Other Insurance.

Medigap Assignment

I Hereby authorize _____ (Medigap/Provider Supplemental) to pay mandated Medigap, benefits directly to Eye Clinics of South Texas, P.A. (Jay M. Rubin, M.D.) for services occurring during the fiscal year _____. I am also authorizing release of all medical information requested by this insurance carrier.

Date Signature

_____ _____

_____ _____

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Services that may not be covered by Medicare/Medicaid/Other Insurance: Refractions, Eye Kit, Medical Eye Tray, Visual Fields, Pressure Check, Removal of Eye Lashes or Fundus Photos,