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Assignment of Insurance Benefits

I hereby assign benefits to be paid on my behalf to Associated Eye Surgical Center, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct.

Disclosure of Ownership Notice

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at Associated Eye Surgical Center may have an ownership interest in Associated Eye Surgical Center. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Associated Eye Surgical Center.

Contact Release Information

I authorize/permit Associated Eye Surgical Center and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

Certification of Patient Information

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

Patient Rights/Advanced Directives Information

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding Associated Eye Surgical Center policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

X

Signature of Patient or Responsible Party

Print Name

Relationship to Patient

Date Signed