

**ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR,
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE**

Patient Name: _____

Employer: _____

Claim/Group: _____

SS# or ID#: _____

I hereby instruct and direct _____ Insurance
Company to pay by check, made out to and mailed to:

**Schwartz Laser Eye Center
8416 E. Shea Blvd., Suite C-101
Scottsdale, AZ. 85260**

Or

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to
make out the check to me and mail it to:

C/O

The professional or medical expense benefits allowable and otherwise payable to me under my current
insurance policy as payment toward the total charges for the professional services rendered. **THIS IS
A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** I have
agreed to pay, in a current manner, any balance of said professional services charge over and above
this insurance payment.

**Refractions are not covered by insurance. The cost of the refraction part of an eye exam will be
\$35, paid in full by the patient on or before the day of the refraction.**

I also authorize the release of any information pertinent to my case to any insurance company, adjuster
or attorney involved in this case.

Date: _____, 2010

Signature of Policy Holder

Witness

Signature of Claimant if other than Policy Holder