Signature on File, Assignment of Benefits, Financial Agreement

Patient Name: _____ OFFICE USE: ID # _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Eye Care & Vision Associates Ophthalmology, LLP, for services furnished to me by Eye Care & Vision Associates Ophthalmology, LLP. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eye Care & Vision Associates Ophthalmology, LLP accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Eye Care & Vision Associates Ophthalmology, LLP, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Eye Care & Vision Associates Ophthalmology, LLP may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Eye Care and Vision Associates Ophthalmology, LLP for reimbursement for services rendered, and (2) any health care provider for continued patient care. Eye Care & Vision Associates Ophthalmology, LLP may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Eye Care & Vision Associates Ophthalmology, LLP maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office, and that Eye Care & Vision Associates Ophthalmology, LLP has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Eye Care & Vision Associates Ophthalmology, LLP if I belong to a plan that does not appear on the above-mentioned list.

5. **NON-COVERED SERVICES:** I understand that Eye Care & Vision Associates Ophthalmology, LLP contracts with health care service plans (i.e., HMOs, PPOs). Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Eye Care & Vision Associates Ophthalmology, LLP to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT**: I agree that in return for the services provided to the patient by Eye Care & Vision Associates Ophthalmology, LLP, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Eye Care & Vision Associates Ophthalmology, LLP for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Eye Care & Vision Associates Ophthalmology, LLP. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Care & Vision Associates Ophthalmology, LLP. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill*.

7. **MEDICATION HISTORY TRANSACTIONS:** I agree to provide Eye Care & Vision Associates Ophthalmology, LLP with information about medications I am already taking to minimize the number of adverse drug events. By signing this consent, I am agreeing that Eye Care & Vision Associates Ophthalmology, LLP can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient Signature or Authorized Party Date