VITREO-RETINAL ASSOCIATES, PC

CONFIDENTIAL PATIENT FORM: SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient's Name: _____ **Date of Birth:** _____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Vitreo-Retinal Associates, PC for the services furnished to me by Vitreo-Retinal Associates, PC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid 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 authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of HCFA 1500 form or elsewhere on other approved claim forms, I agree that my signature authorizes releasing the information to insurer or agency shown. Vitreo-Retinal Associates, PC accepts the charge determination of the Medicare carrier as full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

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 Vitreo-Retinal Associates, PC, if possible, or otherwise to me.

OTHER INSURANCE: I understand that Vitreo-Retinal Associates, PC contracts with health care service plans (ie: HMO's, MMO's, PPO's) related only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by health care service plans not to be covered. Examples of such non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with their health care service plan or in the benefit summary the health care service plan furnishes to the patient, as well as treatment and/or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Vitreo-Retinal Associates, PC to obtain necessary health care service plan authorizations.

RELEASE OF INFORMATION: Vitreo-Retinal Associates, PC 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 Vitreo-Retinal Associates, PC for reimbursement for services rendered, and (2) any health care provider for continued patient care. Vitreo-Retinal Associates, PC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate to 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.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Vitreo-Retinal Associates, PC I will pay my account at the time service is rendered or will make financial agreements satisfactory to Vitreo-Retinal Associates, PC for full payment.

I understand that my copayment and/or deductible is due at the time of service, prior to seeing the doctor and that I will be charged a $10.00 administrative fee for any copayments and/or deductibles not paid at the time of service (i.e.: if I request to be billed for such copayment/deductible).

Please Acknowledge by Initialing: _____

If an account is sent to an attorney or collection agency for collection, I agree to pay any collection expenses and reasonable attorney 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. I further understand that I am required to provide at least a 24 hour notice of cancellation of my appointment and agree that, if I do not provide such notice, I may be charged a $50.00 administration fee, and agree to pay such fee.

Please Acknowledge by Initialing: _____

Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Vitreo-Retinal Associates, PC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Vitreo-Retinal Associates, PC. However, it is clearly understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

Patient/Authorized Party Signature: **Today's Date:**