

SIGNATURE ON FILE, ASSIGNMENT OF BEEFITS, FINANCIAL AGREEMENT

PATIENT NAME:

1. **RELEASE OF INFORMATION:** Midatlantic Eye Center may disclose all or any part of may medical record and/or financial ledger, including information 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 Midatlantic Eye Center for reimbursement of services rendered, and (2) any health care provider for continued patient care.
2. **NON-COVERED SERVICES:** I understand that Midatlantic Eye Center’s contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are “covered” by the health care services plans. 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 service plan or in the benefit summary the health care service plan furnishes to the patient: and treatments or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Midatlantic Eye Center to obtain necessary health care service plan authorizations.
3. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Midatlantic Eye Center, I will pay my account at the time service is rendered or will make arrangement satisfactory to Midatlantic Eye Center for payment. If an account is sent to an attorney for collection, I agree to pay any collection expenses and reasonable attorney’s fee as established by the court and not by a jury in any court action. Any benefit of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is assigned to Midatlantic Eye Center. If co-payment and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Midatlantic Eye Center.
4. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Midatlantic Eye Center for services furnished me by Midatlantic Eye Center. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agent 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 insurance is indicated on the claim form, my signature authorizes releasing the information to the insurer or agency shown. Midatlantic Eye Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance, and uncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
5. The doctors and staff of Midatlantic Eye Center have my permission to discuss my personal health information with: _____
Relationship _____
6. By my signature I acknowledge that the privacy policies and patient rights of the Midatlantic Eye Center have been made available to me.

HOWEVER, IT IS UNDERSTOOD THAT THE UNDERSIGNED AND/OR THE PATIENT ARE PRIMARILY RESPONSIBLE FOR THE PAYMENT OF MY BILL.

Patient Signature or Authorized Party

Date