

Signature on File, Assignment of Benefits, Financial Agreement

1) **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Visionary Ophthalmology, for services furnished to me Visionary Ophthalmology. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services 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 to Visionary Ophthalmology and authorizes the release of medical information necessary to pay the claim. Visionary Ophthalmology accepts the charge determination of the Medicare carrier as the 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.

2) **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS 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 Visionary Ophthalmology, if possible, or otherwise to me.

3) **OTHER INSURANCE:** I understand that Visionary Ophthalmology participates in several medical insurance plans. It is my responsibility to determine physician participation in my plan, coverage, applicable co-pays and any other requirements of my policy. I understand my signature requests that payment be made to Visionary Ophthalmology and authorizes release of medical information necessary to pay the claim. I am responsible for the deductible, coinsurance, co-pay, and non-covered services.

4) **MINOR PATIENTS:** I understand that as the parent/guardian accompanying the patient, I will be fully responsible for payment of services rendered.

5) **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Visionary Ophthalmology, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Visionary Ophthalmology. I understand Visionary Ophthalmology contracts with health care service plans relate only to items and services which are "covered" by the health care service plans. The undersigned accepts full financial responsibility for any non-covered services, co-pays, deductibles, co-insurance or unauthorized services. If my account is sent to a collection agency, 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. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient Name

Date

Signature of Patient or Authorized party

Printed name (if not patient)