ATLANTIC EYE INSTITUTE, P.A.

Signature of file, Assignment of Benefits, Financial Agreement

______________________________ ______________________

Patient Name (print) Account Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Atlantic Eye Institute, P.A., for services furnished me by Atlantic Eye Institute, P.A. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these 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 the HCFA 1500 form of elsewhere on the approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Atlantic Eye Institute, P.A. 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 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 Atlantic Eye Institute, P.A. if possible or otherwise to me.

3. **OTHER INSURANCE:** I understand that Atlantic Eye Institute, P.A. 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 Atlantic Eye Institute, P.A. 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 the Atlantic Eye Institute, P.A. if I belong to a plan that does not appear on the above-mentioned list.

4. **NON-COVERED SERVICES:** I understand that Atlantic Eye Institute's contracts with health care service plans (HMOs, PPOs) relate only to items and services that are "covered" by the health care service 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 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. **A REFRACTION (AN EXAMINATION OF YOUR VISUAL ACUITY) IS NON-COVERED BY MOST INSURANCE PLANS.** The undersigned agrees to cooperate with Atlantic Eye Institute, P.A. to obtain necessary health care service plan authorization.

5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the me/ my dependant by Atlantic Eye Institute, P.A., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Atlantic Eye Institute, P.A. for payment. If an account is sent to a collection agency, I agree to pay collection expenses and reasonable fees as established by the collection agency. 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 Atlantic Eye Institute, P.A. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Atlantic Eye Institute, P.A. However, it is understood that the undersigned and/or patient are primarily responsible for payment of my bill.

6. **AUTHORIZATION TO COLLECT FROM PATIENT'S INSURANCE COMPANY:** I request the direct payment of authorized medical benefits be made to Atlantic Eye Institute for any services furnished me by the physicians of this practice. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries) and its agents, to my attorney or to another physician's office. Also, I permit a copy of this authorization to be used in place of the original copy. This assignment will remain in effect until I revoke, in writing, this authorization. Further, I understand that because these services were performed for me or for my legal dependant, I am financially responsible for all charges whether or not paid by the insurance carrier.

______________________________ ______________________

Patient/or patient's Representative/ signature Date