Signature on File, Assignment of Benefits, Financial Agreement, Consent to Treatment

Beneficiary Name (Please Print):_____

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to the Provider for services furnished me by Provider. 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 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 the HCFA 1500 form or elsewhere on the other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Provider 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 deductibles 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 the 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 the Provider indicated above, if possible or otherwise to me.

3. OTHER INSURANCE: I understand the Provider I have indicated above is in network/contracted with many insurance plans. I agree that I am individually obligated to pay charges in full at time of service for all services rendered to me, if Provider is not in network with my insurance plan.

4. NON-COVERED SERVICES: I accept full financial responsibility for all items or services, which are determined by my health plan 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 plan or in the benefit summary the health care plan furnishes to the patient; and treatment or tests not authorized by the health care plan. I agree to cooperate with Provider C to obtain necessary health care plan authorizations.

5. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by the Provider indicated above, I will pay my account at the time services are rendered or will make financial arrangements satisfactory to Provider. for payment. If an account is sent to a collection agency or attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury or in court action. I understand and agree that if my account is delinquent, a $30 administrative fee may be charged to my account, and I may be charged interest at the legal rate. Any benefits, of any type under any policy, or insurance insuring the patient, or any other party liable to the patient, are hereby assigned Provider. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Provider.

6. CONSENT TO TREATMENT: I authorize the Provider, his or her associates, technical assistants, and other health care providers under Provider's direction to provide diagnostic evaluation and treatment. I agree to pupillary dilation for the purpose of examination and have been advised not to drive if I feel visually impaired. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

Patient/Legal Guardian Signature:_____ Date:_____