ASSOCIATED EYE CARE

Signature on File, Assignment of Benefits, Financial Agreement

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Associated Eye Care for services furnished to me by Associated Eye Care. 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 other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Associated Eye Care accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered 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 Associated Eye Care, if possible, or otherwise to me.
3. **RELEASE OF INFORMATION:** Associated Eye Care 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 Associated Eye Care for reimbursement for services rendered, and (2) any health care provider for continued patient care.
   Exception: Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. Associated Eye Care may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for 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.
   OTHER INSURANCE: I understand that Associated Eye Care has contracted with several health care plans. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Associated Eye Care if I belong to a plan that Associated Eye Care has not contracted with.
4. **NON-COVERED SERVICES:** I understand that Associated Eye Care's contracts with health care service plans (i.e., 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. (i.e., Medicare patients – routine eye exams and refractions.) The undersigned agrees to obtain necessary health care service plan authorizations and/or referrals prior to appointment.
5. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Associated Eye Care, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Associated Eye Care for payment. If an account is sent to an attorney for collection, 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. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefit of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Associated Eye Care. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Associated Eye Care. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. This agreement is valid for one year from the last dated signature.

SIGNATURE: _____ DATE: ___/___/___

Patient Consent to Share Personal Health Information

I hereby authorize Associated Eye Care to share my personal health information with named persons below until further written notice from me:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name: _____
(PRINT)

I acknowledge the receipt of the Notice of Privacy Practices.

Signature: _____

Date: _____ MN WI