Associates In Eyecare

Beneficiary's Name (Print) Medicare ID#

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Associates In Eyecare for services furnished me by Associates In Eyecare. 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 to 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 or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Associates In Eyecare accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

2. MEDIGAP INSURANCE: 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 either to me or on my behalf to Associates In Eyecare.

3. OTHER INSURANCE: I hereby authorize payment of my medical and surgical insurance benefits to Associates In Eyecare. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Associates In Eyecare. I authorize Associates In Eyecare to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

4. NON-COVERED SERVICES: I understand that Associates In Eyecare 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, that 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 furnished to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Associates In Eyecare to obtain necessary health care service plan authorizations.

5. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Associates In Eyecare, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Associates In Eyecare 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 benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Associates In Eyecare. I co-payments and/or deductibles are designated by my insurance company or health plan. I agree to pay them to Associates In Eyecare. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

6. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received Notice of Privacy Practices issued by Associates In Eyecare that was effective April 14, 2003.

X

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

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