SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **L.O. Eye Care** for services furnished me by **L.O. Eye Care**. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE Health Care Financing Administration and its agents any information needed to determine these benefits or the 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. **L.O. Eye Care** 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 **L.O. Eye Care,** if possible, or otherwise to me.

3. **RELEASE OF INFORMATION: L.O. 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 **L.O. Eye Care** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **L.O. Eye Care** may also disclose, without releasing the patient's identity, any information pursuant to State or Federal law, status, or regulation.

4. **OTHER INSURANCE:** I understand that **L.O. Eye Care** maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and I understand that **L.O. Eye Care** has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I, as individual, am obligated to pay the full charges of all services rendered to me by **L.O. Eye Care** if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that **L.O. Eye Care** contracts with health care service plans (i.e., HMOs, PPOs) that specify items and services which 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. The undersigned agrees to cooperate with **L.O. Eye Care** to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by **L.O. Eye Care**, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **L.O. 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 a service fee. 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 **L.O. Eye Care.** If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **L.O. Eye Care**. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

7. **DIVORCED PARENTS:** We do not second party bill. The parent bringing the child to our facility will be responsible for required co-payments, deductibles etc. at the time of service.

8. **PRIVACY PLAN:** I agree that I have been given the opportunity to read and receive a copy of the **L.O. Eye Care Notice of Privacy Practices (Updated as of March 27, 2017).**

9. **NO SHOW FEE:** I understand that L.O. Eye Care may charge a $50.00 no show fee for any appointments not canceled within 24 hours.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____

Patient or Guardian Name (**print**) Medicare Number (as applicable)

_____ _____

Patient or Guardian** Signature Date

** If an authorization is signed by an individual's personal representative, the representative's authority is based on:
_____ (e.g., state law, court order, etc.)