Eye Care ASSOCIATES

Financial Responsibility:

1. Be advised that all profession services rendered are charged to the patient.
2. All necessary Medicare/ Insurance Carrier claim forms will be submitted by our office based on the information provided by the patient.
3. The patient is responsible to notify our office of any changes in insurance coverage, address, or other related circumstances that effect the processing of a claim.
4. The patient is responsible for all fees, regardless of insurance carrier coverage.
5. Payment is expected for services when rendered, unless other payment arrangements have been made in advance by the patient with our billing staff.

Medical Consent for Treatment and Release of Medical Information:

1. I consent to treatment necessary for the below -named patient.

HIPPA Privacy Practices:

1. I have reviewed and, if requested, received a copy of Eye Care Associates, PC HIPPA policy.

Insurance Authorization and Assignment:

1. I request that payment of authorized Medicare/ Other Insurance Carrier benefits be made on my behalf to Eye Care Associates, PC for any services furnished to me. Regulations pertaining to Medicare assignment of benefits apply.
2. I authorize any holder of medical or other information about me to be released to the Social Security Administration and the Centers for Medicare and Medicaid Administration or its intermediaries or Carrier or any Other Insurance Company to furnish information needed for this or a related Medicare/ Other Insurance Carrier claim.
3. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If Item 9 of the HCFA-1500 claim form is completed, my signature authorizes the release of necessary information to the insurer agency shown. In Medicare/ Other Insurance Carrier assigned benefit situations, the rendering provider agrees to accept the charge determination of the Medicare/ Other Insurance Carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare/ Other Insurance Carrier policies.

I have read and understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization and assignment.

Patient name: _____ Date of Birth:_____

Patient / Parent Signature: _____ Date:_____

I have reviewed/ updated my address and telephone number. Initials: _____