Signature on File, Assignment of Benefits, Financial Agreement

_____ _____

Patient Name *(print)* Medicare Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Proffitt Eye Center, for services furnished me by Proffitt Eye Center. 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. Proffitt Eye Center 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 Proffitt Eye Center, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Proffitt Eye Center 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 Proffitt Eye Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Proffitt Eye Center 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.

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

5. **NON-COVERED SERVICES:** I understand that Proffitt Eye Center's contracts with health care service plans (i.e., HMOs, PPOs) relate only to 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 Proffitt Eye Center to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I have read Proffitt Eye Center's Financial Policy and agree that in return for the services provided to the patient by Proffitt Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Proffitt Eye Center 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 Proffitt Eye Center. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Proffitt Eye Center. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.* If I'm charged for failure to keep an appointment without prior notification, I agree to pay this fee.

7. **CONSENT TO TREAT:** I understand that I may have a condition requiring diagnostic procedures, physical examination, and/or medical treatment. I hereby voluntarily consent to such diagnostic procedures (including, but not limited to, laboratory testing and x-ray testing), physical examination, and such medical treatment as deemed necessary by my health care providers. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided at Proffitt Eye Center.

8. **PRE-CERTIFICATION:** I understand that it is my responsibility to ensure that appropriate pre-certification with my insurance company is completed for services provided.

PROFFITT EYE CENTER
711 N. Custer Ave.
Grand Island, NE 68803

X_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Relationship of Representative Witness' Signature

If signed by a Personal Representative, please list the following:

1. The personal representative's printed name:_____
2. The reason that the patient cannot sign:_____
3. On what the personal representative's authority is based: _____