Signature on File, Assignment of Benefits, Financial Agreement

=PATIENT_FULL_NAME= *((TODAYS_DATE))* =Patient_Account_Number=

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Williamson Eye Institute for services furnished me by Williamson Eye Institute. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services 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 CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Williamson Eye Institute accepts the charge determination of 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. RELEASE OF INFORMATION: Williamson Eye Institute 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 Williamson Eye Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care. Williamson Eye Institute 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.

3. OTHER INSURANCE: I understand that Williamson Eye Institute does contract with many, but NOT ALL health care service plans. It is my responsibility to know whether a contract exists with my healthcare provider and my insurance carrier. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Williamson Eye Institute if I belong to a plan that is not contracted. We will bill your insurance once as a courtesy, if your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will assist you only after you have contacted your insurance.

4. NON-COVERED SERVICES: I understand that Williamson Eye Institute'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, **refractions, contact lens fittings and external photographs.** The undersigned agrees to cooperate with Williamson Eye Institute to obtain necessary health care service plan authorizations.

5. FINANCIAL AGREEMENT: All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. **All copays will be collected on the date services are rendered.** We accept cash, check, and credit card of Master Card, Visa, and Discover, as well as Care Credit. Returned checks are subject to a $25.00 return check fee. If there are any changes in your insurance coverage it is your responsibility to notify Williamson Eye Institute immediately. Any unpaid charges over 90 days old will be turned to an outside collection agency with additional collection agency fees. *Exceptions will be made only if you have contacted our business office and made arrangements agreed upon by a member of the business office staff.* You are responsible for any collection fees, legal fees, or court costs incurred in the collections process. In addition once an account has been turned over to a collection agency the patient will be terminated from the practice.