



Assignment of Benefits, Financial Agreement, and Signature on File

Patient Name (print)

Chart #

Date

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Ohio Eye Associates, for services furnished me by Ohio Eye Associates. 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 CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Ohio Eye Associates accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered 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 CMS 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 Ohio Eye Associates, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Ohio Eye Associates 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 Ohio Eye Associates for reimbursement for services rendered, and (2) any health care provider for treatment purposes. Ohio Eye Associates may also disclose information concerning my care 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 Ohio Eye Associates 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 Ohio Eye Associates 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 Ohio Eye Associates if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Ohio Eye Associates contracts with health care service plans (i.e., HMOs, PPOs) related 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 Ohio Eye Associates to obtain necessary health care service plan authorizations.

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

Patient Signature or Authorized Party

Relationship of Authorized Party