Ohio Eye ASSOCIATES

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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 (OEA)/Ohio Eye Optometric (OEO)/Ohio Eye Surgeons (OES) for services furnished to me by OEA/OEO/OES. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable or 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. OEA/OEO/OES 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 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 OEA/OEO/OES, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** OEA/OEO/OES 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 OEA/OEO/OES for reimbursement for services rendered, and (2) any health care provider for treatment purposes. OEA/OEO/OES 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 the place of the original. I authorize the release of any medical information by OEA/OEO/OES for any insurance claims submission and at the doctor's discretion, assign the insurance payment to them for these services. I understand that I am financially responsible for the charges that are not covered.

4. **OTHER INSURANCE:** I understand that OEA/OEO/OES maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. OEA/OEO/OES does not have a 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 OEA/OEO/OES, if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that OEA/OEO/OES contracts with health care service plans (i.e., HMO's PPO's) related only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full 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 OEA/OEO/OES to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by OEA/OEO/OES, I will pay my account at the time service is rendered or will make financial agreements satisfactory to OEA/OEO/OES for payment. Benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to OEA/OEO/OES. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to OEA/OEO/OES. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of the bill.

_____ _____

Patient Signature or Authorized Party Date