

We appreciate the confidence you have expressed by selecting us as your physicians. If you have any questions about our services, fees or other aspects of your care, please feel free to discuss your concerns with us. The best medical service is based on friendly, mutual understanding between the doctor and patient.

You will be provided with an itemized copy of your charges for the visits. Necessary forms will be completed to help expedite insurance carrier payments. However, all patients are expected to pay for services at the time they are rendered unless other arrangements have been made in advance with our business office. We prefer payment prior to sending an end of month statement, as this helps us to contain costs by saving on billing expenditures.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to **The Eye Center** for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable to related services. 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 release of the information to the insurer or agency shown. In Medicare or other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare or other insurance company as the full charge, and the patient is responsible for the deductible, co-insurance, co-pays and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare or other insurance company.

X _____
Signature of patient (or parent if minor)

Date