Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for copays and annual deductibles will be expected at the time of the visit. Glasses prescriptions are considered "routine services" and are not covered by most "medical" insurance policies. I understand a payment of $25 for this service will be collected at the time of the appointment. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to care and treatment prescribed by the physician that is necessary in her judgement.

Release of Information/Assignment of Benefits

I authorize use of this form for all my insurance submissions and authorize release of information needed to process a claim to my insurance companies. I assign all rights for reimbursement of expenses allowed by my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a statement for any balance on my account.

I understand that if I do not have insurance or if the doctor I see today does not participate with my insurance plan, I am responsible for the payment at the time of the visit. I agree to make a down payment of $75.00 upon check in and will pay the balance of the visit upon check out. I will be given a summary of my charges and diagnoses so that I may file with my insurance company to be reimbursed.

Signature:_____Date:_____

Printed Name:_____

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to McElhinney Eye Care, PA, for services furnished to me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the Medicare allowable as the full charge, and the patient is responsible for the deductible, co-insurance and any uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

A Medigap or Medical Supplemental policy is a health insurance policy or other health plan offered by a private company to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. I request that payment of authorized benefits be made on my behalf to McElhinney Eye Care, PA, for any services furnished to me by my physician/supplier. I authorize that any of my medical information be released to my secondary or Medigap insurance carrier, in order to determine and pay benefits for any related services.

This agreement remains in effect until revoked in writing by the patient.

Signature:_____Date:_____

Printed Name:_____