PENINSULA EYECARE

SIGNATURE ON FILE. ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Beneficiary Name (Print) _____ Medicare Number _____

1. **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to Peninsula Eyecare Medical Associates for services furnished me by Peninsula Eyecare. 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 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 HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Peninsula, Eyecare accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
2. **MediGap:** I understand that if a MediGap policy or health insurance is indicated in item 9 of the HCFA 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 Peninsula Eyecare, if possible or otherwise to me.
3. **Release of information:** Peninsula Eyecare may disclose all or 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 Peninsula Eyecare for reimbursement for services rendered, and (2) any health care provider for continued patient care. Peninsula Eyecare 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 collection of statistical date or pursuant to State and Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
4. **OTHER INSURANCE:** I understand that Peninsula Eyecare 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 Peninsula Eyecare 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 Peninsula Eyecare if I belong to a plan that does not appear on the above-mentioned list.
5. **NON-COVERED SERVICES:** I understand that Peninsula Eyecare contracts with health care plans (i.e., Medicare HMOs, IPOs) state items and service 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 to be non-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 L "treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Peninsula Eyecare to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Peninsula Eyecare, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Peninsula Eyecare for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. I agree to pay them to Peninsula Eyecare, However, it is understood that the undersigned and/or the patient are primarily responsible.

_____ _____

Beneficiary Signature or Authorized Party **Date**

PENINSULA EYECARE MEDICAL ASSOCIATES
OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we ask that you read and sign prior to any treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND AMERICAN EXPRESS.
WITH PRIOR CREDIT APPROVAL, WE CAN ARRANGE A PAYMENT PLAN.

Regarding Insurance:

1. As a courtesy to our patients, we will accept assignment of insurance benefits, however, we do require payment of any uncovered portion, such as deductibles and co-payment, to be paid at the time of service.
2. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, any unpaid balance will be due in full.
3. The balance is your responsibility whether your insurance company pays or not.
4. We cannot bill your insurance unless you bring in all insurance information.
5. Account balance over 90 days will be charged a service charge of 18%.
6. If you are a member of a Managed Care Insurance HMO or PPO, it is your responsibility to know your policy provisions and to inform this office.

INITIALS _____

Financial Responsibility

1. Adult patients are responsible for payments at time of service.
2. The adult parent or guardian accompanying a minor is responsible for payment.
3. For unaccompanied minors, non-emergency treatment will be denied unless prior financial arrangements have been made.
4. Financial arrangements are available to our patients, but must be made prior to treatment. Such financial agreements are a commitment on your part as well as ours.
5. A service charge of 18% per annum will be charged on overdue balances over 90 days.

INITIALS _____

Missed Appointments

Without cancellation 24 hours prior to my appointment, I understand that I will be charged $25.00 dollars for each late cancellation or failed appointment. If I fail to keep two consecutive appointments, another appointment will not be scheduled until I have paid any outstanding charges.

INITIALS _____

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy and understand and agree to this financial policy.

_____ _____

Signature of patient/responsible party Date