FRITCH EYE CARE MEDICAL CENTER

Signature on File, Assignment of Benefits, Financial Agreement

Medical: _____ ID# _____

_____ Vision: _____ ID# _____

Patient Name: (PRINT)

Medical: _____ ID# _____

Vision: _____ ID# _____

- **MEDICARE**: I Request that payment of authorized Medicare Benefits be made on my behalf to Fritch Eye Care, for services furnished me by Fritch Eye Care. 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 claims forms, my signature authorizes releasing the information to the insurer or agency shown. Fritch Eye Care 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 based upon the charge determination of the Medicare Carrier.
- **MEDIGAP (Secondary):** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS 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 behalf to Fritch Eye Care, if possible or otherwise to me.
- **PREFERRED PROVIDER ORGANIZATIONS (PPO):** I understand that it is the patient/guarantor responsibility to know if Fritch Eye Care is "IN" or "OUT" of network for my insurance. If my insurance provider is "Out of Network" and I choose to be treated by Fritch Eye Care, I may be responsible for higher out of pocket charges. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Fritch Eye Care.
- **NON-COVERED SERVICES (HMO):** I understand that Fritch Eye Care does not contract with health care services plans (i.e., HMO's, Medicare HMO's and Medi-Cal). Accordingly, the undersigned accepts full financial responsibility for all items or services.
- **RELEASE OF INFORMATION:** Fritch Eye Care may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable diseases, or HIV, to any person or corporation (1) which is or may be liable or under contract to Fritch Eye Care for reimbursement for services rendered, and (2) any health care provider for continued patient care. Fritch Eye Care 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 the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
- **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Fritch Eye Care, I will pay my account at the time of service is rendered or will make financial arrangements satisfactory to Fritch Eye Care 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 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. Any benefits of any type under and policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned Fritch Eye Care. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Fritch Eye Care. ***However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.***

- _____ _____

  Insurance Subscriber's Name (PRINT) Date

  _____ _____

  Patient Signature or Authorized Party Date