Family EyeHealth Center

Dr. Cord Linville, Dr. David Scott

Signature On File, Assignment of Benefits, Financial Agreement

I request that payment of authorized Medicare or other health care insurance benefits be made on my behalf to the Family Eye Health Center. For any services furnished to me by the listed provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services 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. In the case of Medicare, I understand that if "Other Health Insurance" is indicated in the item 9 of the CMS-1500 Form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the change determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carriers.

In the case of non-Medicare health insurance claims, I understand that charges will be submitted to my insurance company and paid to Family Eye Health Center. I understand and agree to pay the amount I'm responsible for, including deductible, coinsurance and noncovered services, at the time the service is rendered.

I request that payment of authorized Medigap/secondary benefits be made on my behalf to Family Eye Health Center. For any services furnished to me by the physician. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.

If I have no healthcare benefits, I agree that in return for services provided by the listed provider, I will pay my account at the time service is rendered.

My signature remains effective from this date until revoked.

_____ _____ _____

Patient Name (Print) *Responsible Party Signature* *Date*

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Relationship to Patient