Financial Contract Agreement

We accept assignment on Part B Medicare patients. You will be expected to pay your deductible and 20% coinsurance. We only file to one secondary policy but we can supply you with an insurance form for you to mail in later after Medicare has paid.

Medicare Authorization
I understand that my signature requests 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 charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Name: ____ Date:_____/______/_______

Signature: ____ Medicare Policy # ___________________

Pasadena Eye Associates is committed to your successful treatment. Please understand that payment of your account is considered a part of your treatment. If you do not have your current insurance card at the time of service you will be treated as a "self pay" patient.

- All co-pays/deductible/co-insurance/non-covered services are due at the time of service.

(we accept Cash, Checks, MasterCard, Visa, Discover & Care Credit))

- All "self pay" patients are asked to pay this visit fee in full at the time of service unless other prior arrangements are made.
- All patients covered under an HMO plan the patient must have a valid referral at the time of their visit
- **All delinquent accounts, 60 days past due, may be placed in collections, you may be responsible for all additional charges incurred to collect this account, including court costs and legal fees, along with a $25 administration fee.**
- **We do not get involved with any litigation accounts, disputed workmen's' compensation cases, divorce decrees, or auto accidents; you will be 100% responsible for full payment at time of service or within 90 days of service with prior arrangements with the billing department**
- The adult accompanying a minor and/or guardians of the minor are the responsible party for payment of account. We accept assignment of benefits for insurance plans that we are contracted with. The balance is your responsibility. Your insurance is a contract between you and the insurance company. We are not a party to that contract or know exactly what benefits are included or excluded in your plan. Please be aware that some, and perhaps all of the services provided may be non-coverer services and not considered reasonable and medically necessary under the Medicare program and/or other medical insurance coverage. We are not liable for any misquoted benefit information. You are fully responsible for verifying the benefits of your policy. If you have no insurance coverage and need financial help, our Business Office personnel will be happy to help you work out an
agreeable payment plan. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary in our area. Please let us know if you have any questions or concerns. I understand and agree to this Financial Contract.

Agreement as stated above:

Signature: ____Date:________________

Release of Information/Assignment of Benefits/Consent to Treat

I authorize the use of this form on all of my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this insurance authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on dispute claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me. The undersigned consents to the medical and surgical are and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider.

Signature: ____Date:______________

The above authorizations are valid for the duration of the patient's care unless retracted in writing by the patient.