Philip J. Penrose, M.D.
Jennifer K. Sablad, O.D.
Brett Fredericks, O.D.
Couture Vision Optical

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name *(print)* _____ Date of Birth _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Eye MD Monterey, for services furnished to me by my provider. 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 HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. My provider accepts the charge determination of the Medicare carrier as the full charge, and **I am responsible only for the deductible, coinsurance and noncovered services**. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other 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 Eye MD Monterey, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Eye MD Monterey may disclose all or any 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 Eye MD Monterey for reimbursement for services rendered, and (2) any health care provider for continued patient care. Eye MD Monterey 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.

4. **OTHER INSURANCE:** I understand that Eye MD Monterey has no contract, expressed or implied, with any plan that they are not contracted. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Eye MD Monterey if I belong to a plan that they are not contracted.

5. **NON-COVERED SERVICES:** I understand that Eye MD Monterey's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services 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 not to be 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 treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Eye MD Monterey to obtain necessary health care service plan authorizations.

_____ (Initials)

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by the providers at Eye MD Monterey, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to them 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. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Eye MD Monterey. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye MD Monterey. ***However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.***

Beneficiary Signature or Authorized Party _____ Date _____