

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS

1) **MEDICARE PATIENTS:** I request that payment of authorized Medicare benefits be made on my behalf to **Long Island Eye Surgical Care, PC** for services furnished me by **Long Island Eye Surgical Care, PC**. 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 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **Long Island Eye Surgical Care, PC** 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.

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 the authorized secondary insurance benefits be made on my behalf to **Long Island Eye Surgical Care, PC**, if possible or otherwise to me.

3) **RELEASE OF INFORMATION:** I authorize **Long Island Eye Surgical Care, PC** to release any medical information necessary to process my claims. This includes any information pertaining to my financial ledger, alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person/corporation to which **Long Island Eye Surgical Care, PC** is liable/under contract with for reimbursement of services rendered and healthcare provider for continued patient care. I also authorize any payment of medical benefits to **Long Island Eye Surgical Care, PC** for services performed.

4) **NON-COVERED SERVICES:** I understand that **Long Island Eye Surgical Care, PC** contracts with insurance plans relates to items which are "**covered**" by the insurance plan. I understand that I accept full financial responsibility for all items or services that are not covered by my insurance plan. Payment for these services are due upon treatment.

5) **FINANCIAL AGREEMENT:** See attached sheet

6) **SELF-PAY PATIENTS:** See attached sheet

7) I understand that the authorizations stated will remain in force until terminated in writing by the patient.

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE