SEWICKLEY EYE GROUP

Financial Agreement and Assignment of Benefits

PATIENT NAME: _____

MEDICARE PATIENTS ONLY:

I request that payment of authorized Medicare benefits be made on my behalf to Sewickley Eye Center, Ltd. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay my claims.
If other insurance is listed in item 9 on the CMS 1500, my signature authorizes release of information to the insurer or agency. I request that payment of authorized secondary insurance benefits be made on my behalf to Sewickley Eye Center, Ltd.
I acknowledge by my signature below that I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based on the charge determination of the Medicare carrier.

All OTHER INSURANCES:

I authorize the release of any medical, vision or other information necessary to process any of my claims. I authorize payment of medical or vision benefits to the undersigned physician or supplier for services provided. I acknowledge by my signature that I am responsible for any balance for non-assigned claims. I acknowledge by my signature that I am responsible for the deductibles, coinsurances, co-pays and any non-covered services. I am also responsible for payment of any claim where proper authorization (referral) was not obtained and my insurance has denied to process and pay.

SELF PAY PATIENTS:

Payment in full is required at the time of visit unless prior arrangements have been made with our billing department.

FINANCIAL AGREEMENT:

I agree in return for the services provided by Sewickley Eye Center, Ltd, I will pay my account in full or make financial arrangements with our billing department. I understand and agree that if my account is delinquent, it will be turned over to our collections department and continued delinquency may result in termination of my care.

_____ _____

Signature of Patient (Authorized Beneficiary if patient is minor) **Date**