THE SEWICKLEY EYE GROUP

MEDICARE PATIENTS ONLY:

I request that payment of authorized Medicare or Medigap 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, or Medigap insurance, any information needed to determine these benefits payable to related services.

I also understand that Medicare does not cover the **refraction** portion of my examination (evaluation for possible vision changes) and that this charge is my responsibility.

PATIENT SIGNATURE: _____ **Date:** _____

COMMERCIAL/ MEDICARE ADVANTAGE/ HMO/ PPO PATIENTS ONLY:

I authorize the release of any medical, vision or other information necessary to process this claim. I authorize payment of medical or vision benefits to the undersigned physician or supplier for services provided. I understand that I am responsible for any balance for non-assigned claims or any co-insurance, co-pay or deductible for assigned claims or for payment of any claim if proper authorization was not obtained.

I also understand that the **refraction** portion of my examination (evaluation for possible vision changes) may not be a covered service and that this charge may be my responsibility.

PATIENT SIGNATURE: _____ **Date:** _____

SELF PAY PATIENTS:

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

PATIENT SIGNATURE: _____ **Date:** _____

AUTHORIZATION TO FAX RECORDS:

I authorize fax transmission of my medical or vision records to other physician offices or hospital as the need arises.

PATIENT SIGNATURE: _____ **Date:** _____

PLEASE COMPLETE OTHER SIDE.