

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (print)

Medicare Number

- 1. MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **ESSENTIAL FAMILY VISION CARE** for services furnished me by **ESSENTIAL FAMILY VISION CARE**. 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. **ESSENTIAL FAMILY VISION CARE** 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 authorized secondary insurance benefits be made on my behalf to **ESSENTIAL FAMILY VISION CARE**, if possible or otherwise to me.
- 3. RELEASE OF INFORMATION:** **ESSENTIAL FAMILY VISION CARE** 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 **ESSENTIAL FAMILY VISION CARE** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **ESSENTIAL FAMILY VISION CARE** may 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 **ESSENTIAL FAMILY VISION CARE** maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that **ESSENTIAL FAMILY VISION CARE** has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by **ESSENTIAL FAMILY VISION CARE** if I belong to a plan that does not appear on the above mentioned list.
- 5. NON-COVERED SERVICES:** I understand that **ESSENTIAL FAMILY VISION CARE'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, 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 **ESSENTIAL FAMILY VISION CARE** to obtain necessary health care service plan authorizations.

I acknowledge that I received a copy of
Julia B. Edwards, O.D., & Trixie I. Eakin, O.D.,
Notice of Privacy Practices

Beneficiary Signature or Authorized Party

Date