AGREEMENT OF RESPONSIBILITY

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles, co-pays and co-insurances may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company. I further understand that I am responsible for all collection and attorney fees which may occur on any unpaid balance.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize the release of information needed to process a claim to all of my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider, its agents and employees to have access to my medical records in order to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me. I agree to pay any unpaid balance due and owing on my account within THIRTY (30) DAYS from the date of the monthly statement.

Primary Insurance

Medicare No: _____
Medicaid No: _____
Commercial Ins. Co: _____
Policy Number: _____

I request payment of authorized Medicare and/or any other insurance benefits be made on my behalf to Williams Eye Institute, P.C. for any services furnished me by that physician/supplier at any clinic, optical or ambulatory service center (ASC) location, as applicable, belonging to the practice. I authorize the holder of my medical information to release to Medicare or any other insurance and their agents any information needed to determine these benefits or the benefits payable to related services.

I understand that 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 or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

Secondary Insurance

Secondary or Supplemental Insurance: _____
Policy #: _____

Complete if you have a Secondary or Supplemental Medicare insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as plan offered by a labor organization to members or former members. This Agreement is in effect until revoked in writing by the patient or legal guardian of the patient.

Williams Eye Institute complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender.

Name: _____ Date: _____

Signature: _____