Patient Agreement Chart:

EYE PHYSICIAN ASSOCIATES S.C.

Name: _____

DOB: _____ Age: _____ Gender: _____

Date: _____ Office: _____

1. **MEDICAL AND SURGICAL CONSENT:** The undersigned consents to medical/surgical treatment which may be performed, including dilating drops, diagnostic procedures, anesthesia, medical or surgical treatment or procedures rendered to the undersigned under the general and special instructions of the patient's physician, assistants or designees. The undersigned also agrees that Eye Physician Associates may obtain electronic files from other healthcare providers or third party benefit payers of any results or information necessary to render treatment, such as health information, diagnostic test results or prescription medications.

2. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Eye Physician Associates for services furnished to me by Eye Physician Associates. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicare Services (CMS) 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 insurance form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eye Physician Associates accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

3. **INSURANCE COVERAGE:** Eye Physician Associates contracts with most of the major health plan payers. However, I recognize that it is my responsibility to check with my insurance company or health care service plan prior to obtaining services to discover whether or not services are covered. I also agree that it is my responsibility to obtain proper authorization, referral or precertification necessary by my health plan. As a courtesy we will file your charges with your insurance company, but we cannot guarantee payment. Many insurance companies have additional stipulations that may affect your coverage. I understand that it is my responsibility to pay for any health care services for which my health plan denies coverage.

4. **NON-COVERED SERVICES:** I understand that Eye Physician Associates contracts with healthcare plans that identify items and services which are "covered services". Accordingly, the undersigned accepts full financial responsibility for all items and services which are ultimately determined by the health care plans not to be covered. Payment for non-covered services is expected at the time of service.

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Name: _____

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5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Eye Physician Associates, I will pay my account at the time service is rendered or upon insurance claim processing. If a payment plan is necessary, I understand that it is my responsibility to call and make financial arrangements satisfactory to Eye Physician Associates or its agent. If an account is sent to an outside company for collection, I agree to pay collection expenses and reasonable attorney's fees, and that my account may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Eye Physician Associates. I agree to payment any copayments and/or deductibles assigned by my insurance company or health plan, and agree to pay them to Eye Physician Associates or its agent.

6. **MINORS:** Patients who are under the age of 18 need parent/guardian consent for their appointment. By signing this agreement, the parent/guardian acknowledges all of the information on this form on behalf of the patient. It is strongly recommended that the parent/guardian accompany the minor to their appointment. Eye Physician Associates reserves the right to verify the identify of any adult accompanying a minor to their appointment. In the event that the minor is coming to the appointment alone, you must make arrangements with our office in advance and give verbal permission in addition to signing this form.

7. **EYE DROP ADMINISTRATION:** I understand as a patient, or parent/guardian of a minor child, that my or my child's eyes may be dilated as part of the exam. Dilation and other drops used during the visit may blur vision and visual function for a period of time, and may make bright lights bothersome. I authorize my physician and/or any assistants designated by my physician to administer dilating drops as part of my examination.

By signing below, you are acknowledging that you have read and understand the Patient Agreement listed above.

X _____ _____

Patient/Responsible Party Signature **Date**

X _____

Patient/Responsible Party Printed Name