Twin Cities Eye
CONSULTANTS

Tel 612-999-2020

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS, SIGNATURE ON FILE

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Twin Cities Eye Consultants, for services furnished me by Twin Cities Eye Consultants. I authorize any holder of medical information about me to release to the 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. Twin Cities Eye Consultants 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 deductibles are based upon the charge determination of the Medicare Carrier.

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 information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Twin Cities Eye Consultants, if possible, otherwise to me.

RELEASE OF INFORMATION: Twin Cities Eye Consultants may disclose all or any part of my medical records 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 Twin Cities Eye Consultants for reimbursement for services rendered, and (2) any health care provider for continued patient care. A copy of this authorization may be used in place of the original.

OTHER INSURANCE: I understand that Twin Cities Eye Consultants 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 Twin Cities Eye Consultants 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 Twin Cities Eye Consultants if I belong to a plan that does not appear on the above-mentioned list.

NON-COVERED SERVICES: I understand that Twin Cities Eye Consultants contact with health care service plans (i.e., HMOs, PPOs) state 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 include, 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 Twin Cities Eye Consultants to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Twin Cities Eye Consultants, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I 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 Twin Cities Eye Consultants. If copayment and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Twin Cities Eye Consultants. However, it is understood that the undersigned and/or the patient are primarily responsible of the payment of my bill.

Print Patient full name

Patient or Authorized Party signature

Date