Center for Sight
www.centerforsight.org

Signature on File, Assignment of Benefits, Financial Agreement

Name: _____ Date: _____ MR#: _____

Is this related to an injury ❑ Yes ❑ No Date of Injury _____ Type of Injury ❑ Work ❑ Auto ❑ Other _____

MEDICARE LIFETIME SIGNATURE ON FILE: I certify that the information given by me in applying for payment under TITLE XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

RELEASE OF INFORMATION: CENTER FOR SIGHT 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 CENTER FOR SIGHT for reimbursement for services rendered, and (2) any health care provider for continued patient care. CENTER FOR SIGHT may also 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.

OTHER INSURANCE: I understand that CENTER FOR SIGHT 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 CENTER FOR SIGHT 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 CENTER FOR SIGHT if I belong to a plan that does not appear on the above mentioned list.

NON-COVERED SERVICES: I understand that CENTER FOR SIGHT's contracts with health care service plans (i.e., HMOs, Pops) 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 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 CENTER FOR SIGHT to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by CENTER FOR SIGHT, I will pay my account at the time the service is rendered or will make financial arrangements satisfactory to CENTER FOR SIGHT for payment. If an account is sent to an attorney for collection, I agree to pay 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 CENTER FOR SIGHT. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to CENTER FOR SIGHT. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

I have read and understand this Signature on File, Assignment or Benefits, and Financial Agreement.

_____ _____

Beneficiary Signature or Authorized Party **Date**

_____ _____ _____

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