EYECARE ASSOCIATES OF COLUMBUS, P.C.
Dr. Daniel K Mickey, Dr. Kerry J Krings, Dr. Ryan B Stevens
1371 29th Avenue, Columbus NE 68601
Phone: 402-564-0545
Fax: 402-564-0078

Signature on File. Assignment of Benefits, Financial Agreement

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to **Eyecare Associates, P.C.** for services furnished me by **Eyecare Associates, P.C.** 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 HFCA 1500 form or elsewhere on other approved claims forms, my signature authorizes releasing the information to the insurer or agency shown. **Eyecare Associates, P.C.** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deduciible, coinsurance and noncovered services. Coinsurance and deductible 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 HFCA 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 by behalf or **Eyecare Associates, P.C.**, if possible or otherwise to me.

OTHER INSURANCE: I understand that **Eyecare Associates, P.C.** maintains a separate contract with each participating insurance plan. The most up to date list is available from the insurance manager. I understand that this list is not allinclusive and it is my responsibility to verify individual participation with my insurance plan. The undersigned agrees to be individually obligated to pay the full charges of all services rendered by **Eyecare Associates, P.C.**, if I belong to a plan inwhich the optometrist of **Eyecare Associates, P.C.** in not participating.

NON-COVERED SERVICES: I understand that **Eyecare Associates, P.C.'s** contracts with health care service plans 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 **Eyecare Associates, P.C.** to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by **Eyecare Associates, P.C.**, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **Eyecare Associates, P.C.** for payment. 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 **Eyecare Associates, P.C.** If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Eyecare Associates, P.C.** However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

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Beneficiary Signature or Authorized Representative Date