Pennsylvania Retina Specialists, PC

SIGNATURE ON FILE
ASSIGNMENT OF BENEFITS
FINANCIAL AGREEMENT

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Patient Name (print)

1. **PATIENTS WITH MEDICARE INSURANCE:** I request that payment of authorized Medicare Benefits be made on my behalf to the Pennsylvania Retina Specialists, for services furnished me by Pennsylvania Retina Specialists. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services any information needed to determine benefits payable for related services. I understand that by my signature below I am requesting that payment be made and I authorize release of medical information necessary to pay the claim. My signature below authorizes release of the information to an insurer or agency which is secondary or tertiary to my Medicare coverage. Pennsylvania Retina Specialists accepts the charge determination of the Medicare carrier as the full charge, and **I am responsible only for the deductible, co-insurance and non-covered services.**

2. **PATIENTS WITH SUPPLEMENTAL INSURANCE:** I understand that if a Medicare supplemental policy or other secondary health insurance is indicated, my signature below authorizes release of the information to the insurer or agency so indicated. I request that payment of authorized secondary insurance benefits be made on my behalf to Pennsylvania Retina Specialists if possible or otherwise to me and I will forward same payment to Pennsylvania Retina Specialists.

3. **PATIENTS WITH OTHER INSURANCE:** I understand that Pennsylvania Retina Specialists maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. I agree that I am individually obligated to pay the full charges of all services rendered to me by Pennsylvania Retina Specialists if I belong to a plan that does **not** appear on the above mentioned list.

4. **(ALL PATIENTS) NON-COVERED SERVICES:** I understand that Pennsylvania Retina Specialists' contracts with health care insurance plans (i.e. HMO's, PPO's) relate only to items and services which are "covered" by the insurance plans. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care insurance 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 the insurance plan or in the benefit summary the insurance plan furnishes to the patient and treatment and tests not authorized by the health care insurance plan. I agree to cooperate with Pennsylvania Retina Specialists to obtain necessary authorizations. I acknowledge that treatment decisions are made by Pennsylvania Retina Specialists solely on the basis of medical necessity and the availability of insurance coverage is not a factor in this decision making process.

Continued on Other Side →

5. (ALL PATIENTS) FINANCIAL AGREEMENT:

- I agree that in return for the services provided to the patient by Pennsylvania Retina Specialists, I will pay my account at the time service is rendered or I will make financial arrangements satisfactory to Pennsylvania Retina Specialists for payment.
- If my account becomes delinquent and is sent to an outside collection agency or attorney, I will be responsible for the collection costs incurred by Pennsylvania Retina Specialists to the extent permitted by law (up to 33% of the balance due) along with reasonable attorney fees and court costs, should the matter go to court for resolution.
- If a co-payment or deductible is designated by my insurance company or health plan, I agree to pay it to Pennsylvania Retina Specialists at the time of service and I understand that if I come to my appointment unprepared to pay, my appointment may be rescheduled. I understand that if Pennsylvania Retina Specialists agrees to see me regardless of my inability or refusal to pay an applicable co-payment or deductible and I must be billed for my co-payment, a $5.00 processing fee will be incurred.
- I understand that responsibility for the payment of my bill rests with me.
- I am aware that there will be a $20.00 charge per incident of returned checks.

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Signature of patient or authorized party **Date**