

Patient Responsibility

Agreement of Responsibility

I understand that professional services are rendered to the patient and that the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treatment

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due from me.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to California Eye Professionals, Medical Group, Inc. for any services furnished to me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that 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 or electronically submitted claims, my signature authorizes the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

I authorize the release of payment of medical benefits by my Medigap insurance to my physician. A Medigap or Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as the policy or plan offered by a labor organization to our members or former members.

This agreement is in effect until revoked in writing by the patient.

Signature: _____
Signature - Patient or Representative

Date: ____ / ____ / ____

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient: _____

In front of: _____
Printed name – Practice Representative