

Financial & Insurance Authorizations

FINANCIAL/MEDICAL RELEASE

AUTHORIZATION (All patients or guarantor must sign)

I hereby give my consent to the doctors, staff and associates of Franklin-Altman Family Eye Care, PLLC to provide eye care services to myself and/or family. I understand and agree (**regardless of my insurance status**) that I am ultimately responsible for the balance of the account.

Signed _____ Date: _____

Patient or Guarantor

INSURANCE POLICY (All patients or guarantor must sign)

Changes made daily among insurance companies, make it impossible for us to accept the responsibility of knowing if your plan dictates benefits, payments, coverage and whom you can and cannot see. *As a service to you,* we will file your insurance and check on unpaid claims if not paid in sixty (60) days. In order for us to file your insurance, please provide all insurance information on the day of your visit.

It remains the responsibility of the patient to know his or her own plan. It is also the patient's responsibility to know what his or her insurance allows regarding the frequency of exams. *As a service to you,* we will call your insurance company for an estimate of what they will pay. It is important to know that any information given over the phone cannot be guaranteed and is only an estimate.

The day of your exam, we require that you pay your estimated difference between insurance payments and the provider charges. Again, this is only an estimate and we will either reimburse or bill you if there is a difference in actual benefits paid. If you do have a credit balance on your account, a refund check will be mailed to you within 30 days. If you have a balance on your account after insurance has paid, the balance is due within **30 days of this payment.** We will send a statement to you.

Signed _____ Date: _____

Patient or Guarantor

INSURANCE (Signature on file)

MEDICARE PATIENT

I request that payment of authorized Medicare benefits and/or Medigap benefits be made on my behalf to Franklin-Altman Family Eye Care, PLLC. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services.

I understand that Medicare does not pay for routine services or materials. Materials such as eyeglasses or contact lenses may be considered a one-time benefit cataract surgery; otherwise, I am responsible for all material charges. In the event that Medicare does not pay for a **procedure**** I will be financially responsible and pay Franklin-Altman Family Eye Care, PLLC for all charges.

****Refractive Service CPT 92015 is not covered by Medicare** (this is part of the evaluation that determines your need for eyeglasses).

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signed _____ Date: _____

Patient or Guarantor

NON MEDICARE PATIENT

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits in which I am entitled to Franklin-Altman Family Eye Care, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signed _____ Date: _____

Patient or Guarantor