Miramar

EYE INSTITUTE

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES	INITIAL

ASSIGMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE MIRAMAR EYE INSTITUTE OF ANY AND ALL MEDICAL BENEFITS APPLICABLE AND OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE MIRAMAR EYE INSTITUTE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

RELEASE OF INFORMATION: I HEREBY AUTHORIZE THE MIRAMAR EYE INSTITUTE TO FURNISH MY INSURANCE COMPANY OR COMPANIES, OR THEIR REPRESENTATIVES WITH ANY AND ALL INFORMATION THAT MAY BE CONTAINED IN THEIR MEDICAL RECORDS.

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMIDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THE MIRAMAR EYE INSTITUTE ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS BE MADE TO THE HOLDER OF THIS ASSIGMENT ON MY BEHALF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY HEALTH DEDUCTIBLES AND COINSURANCE.

MEDIGAP: I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE ON MY BEHALF TO THE MIRAMAR EYE INSTITUTE FOR ANY SERVICES FURNISHED TO ME BY THEM. I AUTHORIZED ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO _____ ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I DO NOT NEED TO PROVIDE MY SUPPLEMENTAL INSURER WITH INFORMATION CONCERNING THIS MEDICARE CLAIM, BECAUSE MY SIGNING THIS AUTHORIZATION WILL CAUSE MEDICARE PAYMENT INFORMATION TO CROSS OVER AUTOMATICALLY.

LIABILITY/INSURANCE WAIVER: I HEREBY STATE THAT I WISH THE MIRAMAR EYE INSTITUTE TO SUBMIT MY CLAIM FOR MEDICAL SERVICES TO _____ FOR SERVICES RENDERED FOR THE ACCIDENT DATE OF _____. I AM NOT FILING THIS CLAIM WITH ANY OTHER LIABILITY INSURANCE AND WILL NOT BE MAKING ANY CLAIM TO ANY OTHER GENERAL LIABILITY INSURANCE OR COMPANY. I ALSO UNDERSTAND THAT IF I DO SUBMIT THIS TO ANY OTHER GENERAL LIABILITY INSURANCE OR COMPANY THAT _____ WILL HAVE TO BE REFUNDED IMMEDIATELY AND THE TOTAL AMOUNT ORIGINALLY CHARGED FOR THE SERVICES RENDERED WILL BECOME DUE AND PAYABLE BY ME. FILING YOUR LIABILITY INSURANCE DOES NOT CONSTITUTE AN ASSIGMENT. IF THIS IS A LEGAL,WE DO NOT ACCEPT ASSIGNMENT PENDING THE OUTCOME OF YOUR CASE. YOU ARE RESPONSIBLE FOR YOUR BILL IN ITS ENTIRETY.

IF THE PATIENT IS UNDER 18: I HEREBY GIVE MY PERMISION FOR _____ _____TO BE TREATED BY DR. KENNETH O. KARP.

_____ _____ _____

SIGNATURE/TELEPHONE VERIFICATION WITNESS DATE

PLEASE READ: THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. ALL CHARGES ARE DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLE, CO-PAYS AND NON-COVERED SERVICES NOT PAID BY MY INSURANCE COMPANY. IF A CHECK IS RETURNED, THERE WILL BE A $15 SERVICE CHARGE. IF MY ACCOUNT BECOMES DELINQUENT IN PAYMENT, I AGREE TO PAY ALL COSTS OF COLLECTION INCLUDING A REASONABLE ATTORNEY'S FEE.

METHOD OF PAYMENT: ☐ **CASH** ☐ **VISA** ☐ **M/C** ☐ **DISCOVER**

_____ _____ _____

DATE PATIENT/ GUARDIAN SIGNATURE WITNESS

THESE AUTHORIZATION MUST BE SIGNED IN ORDER TO EXPEDITE THE FILING OF YOUR INSURANCE CLAIM