

Jefferson Eye Surgeons, LLP

826 Washington Street, Suite 100, 102, Watertown, NY 13601
6 A Fuller Street Alexandria Bay, NY 13607

Creative Optical, LLC

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**(Jefferson Eye Surgeons, LLP and Creative Optical, LLC shall be collectively referred to as the "Practice")
2012 Financial Agreement, Signature on File, Assignment of Benefits, Notice of Privacy**

1. Financial Agreement: I agree that in return for the services provided to me by the Practice I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the Practice for payment. We accept cash, checks, CareCredit, Visa or MasterCard.

2. Copayments/ Deductibles: If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the Practice at the time of service. If I fail to pay my copayment at the time of service for any reason, I agree to pay an additional \$5 billing service fee.

3. Non-Covered Services: I understand that the Practice contracts with health care service plans (i.e., HMOs, PPOs) 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 the Practice to obtain necessary health care service plan authorizations.

4. Collections: I acknowledge and agree that should my account be referred for collection with American Profit Recovery, I will pay a collection expense of \$15.00 for each referral, plus any reasonable attorney's fees. Any benefits, of any type, under any policy of insurance insuring the patient, or any other party liable for the patient, are hereby assigned to the Practice. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

5. Cancel / Reschedule Appointments: The Practice requires notice to change or cancel appointments, preferably 24 – 48 hours notice. If a patient misses an appointment without a prior phone call to our office, **there will be a missed appointment charge of \$25.00.**

6. Returned Check Fee: I understand and agree to pay a **\$35 service charge** to the Practice for any checks returned for insufficient funds.

7. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to the Practice, for services furnished me by the Practice. 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 CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The Practice, accepts the charge determination of the Medicare carrier as the full charge, and **I am responsible only for the deductible, coinsurance and non-covered services.** Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

8. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS- 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 my behalf to the Practice, if possible or otherwise to me.**

9. OTHER INSURANCE: I understand that the Practice contracts with health care service plans. **The undersigned agrees that I am individually obligated to pay the full charges at the time of service of all services rendered to me by the Practice if I belong to a plan the Practice does not have a contractual agreement.** Information on covered plans can be provided by the Practice's Billing Department.

10. RELEASE OF INFORMATION: The Practice may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation for any of the following purposes, as each are discussed in more detail in the Practice's Notice of Privacy Practices: (1) payment matters, including reimbursement to the Practice for services rendered, (2) treatment and continued patient care, and (3) health care operations. The Practice may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. I have the right to request restrictions on the uses and disclosures of my protected health information; however, the Practice is not required to agree to such request. I have the right to revoke this consent in writing at any time; however, such revocation shall not affect any prior uses and/or disclosures made by the Practice. I am aware that I have the right to review the Notice of Privacy Practices, and that the same may be amended from time to time. In the event of such amendment, I am entitled to a copy of updated Notice of Privacy Practices, which shall be made available to me at all office locations and electronically on the Practice's website. A copy of this consent / authorization may be used in place of the original.

Beneficiary (Patient) Name (*print*)

Beneficiary (Patient) Signature or Authorized Party

Date

NOTICE OF PRIVACY PRACTICES: I have been offered / presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. **Only need to sign once at first appointment.**

Signed: _____ Date: _____ Relationship to Patient: _____

Internal Use Only: If patient's representative refuses to sign acknowledgement please document date and time notice was presented to patient and sign:

Presented on: _____ at _____ By _____