ASSIGNMENT OF INSURANCE BENEFITS / RELEASE OF INFORMATION

I authorize payment of medical benefits to Shoreline Ophthalmology, P.C. for all services rendered during my visit. I understand that I am financially responsible for all charges whether or not these are paid for by my insurance. I authorize Shoreline Ophthalmology, P.C. to release all information necessary to secure payment from my insurance company on my behalf. I authorize Shoreline Ophthalmology, P.C. to release my medical records to: **1.** Any third party responsible for paying for my care; **2.** Any outside peer review or an auditing agency engaged by a third party payer to review my medical records; **3.** Any third party health care service provider responsible for my personal care including but not limited to hospitals and consulting physicians; **4.** To my spouse or any other person I designate in writing as my agent and/or patient advocate to act for me as permitted by State and Federal law. A photocopy of this assignment shall be considered valid as an original.

TERMS OF CREDIT

All services provided, including co-pays and refraction *(the refraction allows my physician to properly evaluate my visual acuity and overall eye health),* are due and payable at the time of my appointment unless I have a participating insurance plan or other arrangements have been pre-approved by Shoreline Ophthalmology, P.C. I acknowledge that I am responsible for and guarantee the payment of my account balance and all obligations payable to Shoreline Ophthalmology, P.C. regardless of the status of my insurance. I understand that if I have insurance coverage, that my insurance policy is an agreement between me and my insurance company. If payment from my insurance company is insufficient to settle my bill in full, the remaining balance and payment will remain my responsibility. All monthly statements are due and payable within 30 days. Any outstanding balances after 30 days will accrue a 1.5% monthly late fee. If my account remains unpaid after 120 days and payment arrangements were not made prior, my account may be placed into collections or small claims court. Shoreline Ophthalmology, P.C. offers a prepayment plan option with Care Credit if I am unable to pay my account balance. I authorize Shoreline Ophthalmology, P.C. to verify my employment status for purposes of collecting any unpaid balance on my account.

MEDICARE & MEDICARE ADVANTAGE PLANS

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration its intermediaries, or insurance carriers, any information required for this or any related claim to my Medicare or Medicare Advantage Plan. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance either to myself or to the party who accepts assignment.

REFRACTION

I understand that the physician may perform **"refraction**" as part of my eye exam. The refraction allows my physician to properly evaluate my visual acuity, and to determine the overall health of my eyes. It is my understanding that my insurance may not consider the refraction a covered benefit but some secondary vision plans may pay this charge. If the physician performs the refraction as part of my exam, I understand that I will be expected to pay this charge at the time of my appointment.

Patient Signature: _____ Date: _____

or

Responsible Party Signature: _____ Date: _____