Signature on File, Assignment of Benefits, Financial Agreement

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Beneficiary Name *(print)*

1. **MEDICARE:** I authorize **VENTURA OPHTHALMOLOGY** to request payment of authorized Medicare benefits on my behalf for services furnished me by **VENTURA OPHTHALMOLOGY.** I authorize any holder of medical information about me to release to the 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 HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. If I have secondary medical insurance I am responsible for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. **VENTURA OPHTHALMOLOGY** normally does not accept Medicare assignment. If I only have Medicare coverage I am responsible for the difference between the Medicare fee and what Medicare pays toward that fee.

2. **MEDIGAP AND PRIVATE INSURANCE:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 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 insurance or secondary insurance benefits be made on my behalf to **VENTURA OPHTHALMOLOGY.**

3. **RELEASE OF INFORMATION: VENTURA OPHTHALMOLOGY** 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 (1) which is or may be liable or under contract to **VENTURA OPHTHALMOLOGY** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **VENTURA OPHTHALMOLOGY** 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. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE: I** understand that **VENTURA OPHTHALMOLOGY** maintains a list of health care service plans with which it contracts. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by **VENTURA OPHTHALMOLOGY** if I belong to a plan for which **VENTURA OPHTHALMOLOGY** has no contractual agreement.

5. **NON-COVERED SERVICES:** I understand that **VENTURA OPHTHALMOLOGY** contracts with health care service plans. 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 **VENTURA OPHTHALMOLOGY** to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by **VENTURA OPHTHALMOLOGY,** I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **VENTURA OPHTHALMOLOGY** for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to **VENTURA OPHTHALMOLOGY.** If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to **VENTURA OPHTHALMOLOGY.** *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. California Medical Board Health & Safety code section 123110, our office may charge $15.00 to $35.00 for release of records.*

7. Cancellation policy: I understand there will be an $80.00 fee for all missed appointments without 48hour cancellation notice.

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Beneficiary Signature or Authorized Party Date