SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL POLICY & AGREEMENT

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Laurel Eye Clinic, PC, for services furnished me by J. M. Beddingfield, OD. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services 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 claims forms, my signature authorizes releasing the information to the Insurer or agency shown. Laurel Eye Clinic, PC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deducible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. ** MEDICARE DOES NOT PAY FOR ROUTINE VISION SERVICES: A REFRACTION FEE OF $30 WILL APPLY TO ALL MEDICARE PATIENTS WHO NEED A REFRACTION FOR CORRECTIVE LENSES.

2. A Crossover Claim is the transfer of processed claim data from Medicare operations to Medicaid (or state) agencies and private insurance companies that sell supplemental insurance benefits to Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits (COB) program identifies the health benefits available to a Medicare beneficiary and coordinates the payment process to ensure appropriate payment of Medicare benefits.

3. RELEASE OF INFORMATION: Laurel Eye Clinic, PC may disclose all or any part of my medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract to Laurel Eye Clinic, PC for reimbursement for services rendered, and (2) any healthcare provider for continued patient care. Laurel Eye Clinic,PC 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 the authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that Laurel Eye Clinic, PC maintains a list of health care service plans and vision care plans with which it contracts. A list of such plans is available from the business office that Laurel Eye Clinic, PC has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Laurel Eye Clinic, PC if I belong to a plan that does not appear on the above-mentioned list.

5. NON- COVERED SERVICES: I understand that Laurel Eye Clinic, PC's contracts with health care services plans and vision care plans relate only to items and services which are covered by the health care service plans and vision care plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans or vision care plans not to be covered. The undersigned agrees to cooperate with Laurel Eye Clinic, PC to obtain necessary health care service plan and vision care plan authorizations.

6. FINANCIAL POLICY: You will be asked to provide your insurance card(s) at every visit. This is to ensure that the information we have is correct, and that your plan is current and one in which we participate. Out-of-date cards with incorrect information or the wrong insurance cards can cause unnecessary delays in the payment of your claim and the balance may ultimately become your full responsibility. All office copays are to be paid at the time of service. We accept cash, check or credit cards.

We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for medical/vision care is a contract between you and the carrier. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer, or to your agent.

Insurances vary in their coverage, and it is the patient's responsibility to understand his/her benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. Patients are responsible for any co-insurance, deductibles, and any other non-covered billable services.

WE DO NOT BILL THIRD PARTIES such as secondary insurance, Workman's Compensation, Life Insurance, Disability Insurance, Accident Insurance, attorneys, etc. It is the responsibility of the patient to satisfy any outstanding balances. We will provide statements as proof of payment for patients to pursue reimbursement from the from the third-party payer. You can choose to self-pay for the services at the time of the visit and await reimbursement from the third party.

7. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Laurel Eye Clinic, PC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Laurel Eye Clinic, PC 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 Laurel Eye Clinic, PC. The copays and deductibles are designated by my vision plan or health plan, I agree to pay them to Laurel Eye Clinic, PC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.