

## MEDICAL INSURANCE VS CASH PAY

By signing this form I consent to have my Medical Insurance billed instead of paying cash. I am responsible for all services rendered that my Medical Insurance does not cover. Some of the items my Medical Insurance may not cover includes, Contact lens fittings, Visual Fields, Fundus Photos and Anterior Segment photos. There may be other services that I need where my Medical Insurance does not cover. It has been explained that I may have a deductible. If I do have a deductible and chose to use my Medical Insurance then I am responsible to pay my deductible to Legacy Eye Care.

An Example of a Deductible is Medicare. Medicare patients must meet their deductibles every calendar year of \$240. in order for Medicare to start covering 80% of my Insurance coverage.

Note: We bill your insurance company as a courtesy to our patients. Most insurance policies only pay a portion of your total charges. If you have questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that the benefit requirements such as referrals etc for your insurance plan is also your responsibility. Please contact your representative or primary care doctor's office to obtain the information needed for your visit with us. Please understand that financial responsibility for your account is yours, not your insurance company's.

I authorize the release of my medical or other information necessary to process insurance claims. I also request payment of government benefits to the physician or supplier for services.

By signing this form, you consent to use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosure in reliance on your prior consent.

I understand that the above services may or may not be covered by my insurance plan. I will be financially responsible for payment of these services.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_