SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, HIPAA NOTICE

_____

Patient Name (print)

1. **HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received the Notice Of Privacy Practices issued by Martino Eyecare that was effective April 1, 2005.

2. **RELEASE OF INFORMATION:** Martino Eyecare may disclose all or 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 Martino Eyecare for reimbursement for services rendered, and (2) any health care provider for continued patient care. A copy of this authorization may be used in place of original.

3. **NON-COVERED SERVICES:** I understand that Martino Eyecare contracts with health care service plans (i.e., HMO's, PPO's) relate only to items and services which are "covered" by 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, including refraction fee (which is not covered by Medicare)**. I agree to cooperate with Martino Eyecare to obtain necessary health care service plan authorizations.

4. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to me by Martino Eyecare, I will pay my account at the time service is rendered. IF my account is sent to an agency 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 are hereby assigned to Martino Eyecare. If co-payments and /or deductibles are designated by my insurance company or health plan, I agree to pay them to Martino Eyecare. However, I understand that I am primarily responsible for the payment of my bill.

5. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Martino Eyecare, for services furnished to me by Martino Eyecare. I authorize any holder of medical information about me to release 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 authorized 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 authorized releasing the information to the insurer or agency shown. Martino Eyecare accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

6. **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 insurance or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Martino Eyecare, if possible, or otherwise to me.

7. **OTHER INSURANCE:** I authorize payment of my medical and surgical insurance benefits to Martino Eyecare. I understand that I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Martino Eyecare.

8. _____ _____

Patient Signature or Authorized Party **Date**