Hayden Vision

Signature on File, Assignment of Benefits & Financial Agreement

Patient's Printed Name _____ **Social Security #** _____

Medicare: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Hayden Vision for any services furnished to me by Hayden Vision. I authorize any holder of medical information about me to be released 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.

_____ _____

Name of Beneficiary **Medicare/Medicaid Number**

Medigap: I request that payment of authorized Medigap benefits be made either to me or on my behalf to Hayden Vision for any services furnished to me by Hayden Vision. I authorize any holder of medical information about me to be released to my Medigap Insurer with any information needed to determine these benefits or the benefits payable for related services.

Medigap Policy Number _____

Other Insurance: I request that payment of authorized insurance benefits be made by me or on my behalf to Hayden Vision for any services furnished to me by Hayden Vision. I authorize any holder of medical information about me to be released to my insurance company with any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Name of Beneficiary **Name of Insured, if Different**

Self-Pay Patients: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Send an itemized receipt with your claim to your insurance carrier who will then reimburse you directly.

Co-Payments: By law we MUST collect your carrier designated co-pay at the time of service. Please be prepared to pay that co-pay at each visit.

Release of Information: Hayden Vision 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 Hayden Vision for reimbursement for services rendered, 2) any healthcare provider/giver for continued patient care. A copy of this authorization may be used in place of the original. 3) Family members unless otherwise indicated by patient.
I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES. _____ (**Initial**)

List anyone that you do not want information released to: _____

Non-covered Services: I understand that Hayden Vision contracts with healthcare service plans state items for services which are "covered" by healthcare service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services. **Refractions:** A refraction fee of $25.00 is the responsibility of the patient. Medicare mandates this as a non-medical charge and therefore it is not covered under private insurance, Medicare or Medicaid.

Financial Agreement: I agree that in return for services provided to the patient by Hayden Vision, I will pay any amount my insurance does not cover, including deductibles and/or co-payments at the time that services are rendered, or I will make financial arrangements that day satisfactory to Hayden Vision. If my account is sent to a collection agency, I agree to pay reasonable collection expenses. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Hayden Vision. However, it is understood that the undersigned and/or patient are primarily responsible for the payment of my bill.
Authorization: I authorize the Doctors and Staff at Hayden Vision to examine my eyes and perform any services normally associated with an eye examination.

_____ _____

Patient Signature or Authorized Party **Date**