Mississippi Eye Care Associates

Signature on File – Assignment of Benefits
Financial Agreement – Privacy Policy

Medicare: I request that payment of authorized Medicare benefits be made on my behalf and be assigned to Medical Mall Vision Clinic for service rendered to me by Medical Mall Vision Clinic. I authorize release to the Centers for Medicare and Medicaid Services and its agents, any information needed to determine 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.

Medical Mall Vision Clinic accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance and non-covered services based on the charge determination of the Medicare Carrier,

Medigap: I understand that if a Medigap (secondary) policy or other health insurance is indicated in item 9 of approved claim forms; my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Medical Mall Vision Clinic.

Other Insurance: I understand that Medical Mall Vision Clinic maintains a list if insurance plans and carriers with which they have contracts. A list of plans is available from the business office. Furthermore, Medical Mall Vision Clinic has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned that I am individually obligated to pay the full charges of all services rendered to me by Medical Mall Vision Clinic if I belong to a plan that does not appear on the above mentioned list.

Financial Agreement: I agree in return each time services are provided to me (patient) by Medical Mall Vision Clinic , I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Medical Mall Vision Clinic for payment. If my insurance does not pay, designates co-payments and other deductibles, I agree to pay Medical Mall Vision Clinic. However it is understood that the undersigned and/or the patient is primarily responsible for the payment of my Statement of Charges.

I have received a copy of Mississippi Eye Care Assoc. <u>Privacy Practice Policy</u>

_____Date_____
Patient signature or guardian