Texas Eye and Laser Center

1872 Norwood Drive, Hurst, Texas 76054 *1350 So. Main Street, Ft Worth, Texas 76104*
1-817-540-6060 1-877-57LASIK
www.lasikdr.com

Brian D. Ranelle, D.O. ***Jerry G. Hu, M.D.*** ***Stacey Webb, O.D.***

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Notice

Patient Name: DOB:

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Texas Eye and Laser *Center* for services furnished me by *Brian D. Ranelle, D.O., Gang Hu, M.D. or Stacey Webb, O.D.*. 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 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, my signature authorizes releasing the information to the insurer or agency shown. *Texas Eye and Laser Center* accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form, 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 *Texas Eye and Laser Center*, if possible or otherwise to me.

3. **OTHER INSURANCE**: I authorize payment of my medical and surgical insurance benefits to *Texas Eye and Laser Center*. I understand 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 *Texas Eye and Laser Center*. I authorize *Texas Eye and Laser Center* to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

4. **NON-COVERED SERVICES:** I understand that *Texas Eye and Laser Center's* contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. I agree to cooperate with *Texas Eye and Laser Center* to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to me by *Texas Eye and Laser Center*, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to *Texas Eye and Laser Center* for payment. 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 also understand that any insufficient fund returned checks will be charged a $25.00 returned check fee. Any benefits of any type under any policy of insurance are hereby assigned to *Texas Eye and Laser Center*. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to *Texas Eye and Laser Center*. **However, I understand that I am primarily responsible for the payment of my bill.**

6. **HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received the Notice of Privacy Practices issued by *Texas Eye and Laser Center* that was effective April 14, 2003.

7. **REFRACTION POLICY:** I understand that the Refraction is the process of determining the need for Corrective Lenses and Glasses. It is an essential part of an Eye Examination, but it is not a covered service by Medicare and most Insurances. *Texas Eye and Laser Center's* fee for the Refraction is **$30.00** and is due at the time of check out.

Patient Signature or Authorized Party **Date**

KK 0506 08