TEXAS EYE AND LASER CENTER
DR. BRIAN D. RANELLE DR. JERRY G. HU

*1872 Norwood Drive, Hurst, Texas 76054* *3405 Locke Ave., Ste. 100, Ft. Worth, Texas 76107*
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***Brian D. Ranelle, D.O.*** ***Stacey Webb, O.D.*** ***Jerry G. Hu, M.D.***
***Keith Head, O.D.*** ***Megan Solis, O.D.*** ***D'Laine Heisterkamp, 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., Jerry G. Hu, M.D., Keith Head, O.D., Stacey Webb, O.D., Megan Solis, O.D. or D'laine Heisterkamp, 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 services are 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. In addition, I authorize *Texas Eye and Laser Center* and its assignees, and third-party collection agents to use any contact information I have provided to communicate with me regarding my account. I understand and agree that any of these entities may contact me by manual dialing or by using an automatic telephone dialing system, and they may use an artificial or pre-recorded voice. I understand that these calls may be to my home phone, cellular phone, and I consent to such calls. I also agree to receive text messages on my cellular device and e-mails sent to any e-mail address I may provide. I understand that any consent provided hereunder may be revoked by me at any time, by informing *Texas Eye and Laser Center* its assignees, and/or third-party collection agents of such revocation of consent.

**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**