

GEORGE R. REISS, M.D.,P.C.

SHAMIL S. PATEL, M.D.

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

MEDICARE: Medicare#: _____. I request that payment of authorized Medicare benefits be made on my behalf to Dr. Reiss or Dr. Patel for services furnished me by Dr. Reiss or Dr. Patel. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents and 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 HCFA 1500 form, my signature authorizes releasing the information to the insurer or agency shown. Dr. Reiss or Dr. Patel 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.

MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in the item 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 Dr. Reiss or Dr. Patel, is possible or otherwise me.

OTHER INSURANCE: As a courtesy, Dr. Reiss or Dr. Patel will bill all primary insurance coverage if he is a contracted provider. If he is not a contracted provider, I will pay for all services at the same time they are rendered. I authorize payment of my medical and surgical insurance benefits to Dr. Reiss or Dr. Patel. **I understand I am financially responsible for any charges whether or not paid by my insurance.** If co-payment and/ or deductibles are designated by my insurance company or health plan, I agree to pay them to Dr. Reiss or Dr. Patel. I authorize Dr. Reiss or Dr. Patel to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be in place of the original.

NON-COVERED SERVICES: I understand that Dr. Reiss's or Dr. Patel contract with health care services plans (i.e., HMO's, PPO's) relates only to items and services which are "covered" by the health care service plans. These procedures may include, but are not limited to refractions. A refraction may be performed to verify whether or not my vision can be improved with a new prescription or whether surgery is indicated. A refraction is considered routine by Medicare and most other 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.**

FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Dr. Reiss or Dr. Patel, I will pay my account, including co-pay, deductible, and non-covered fees at the time service is rendered. **If I am unable to pay at the time of service, I understand a \$25 billing fee will be charged.** 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 pay 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 Dr. Reiss or Dr. Patel. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Dr. Reiss or Dr. Patel.

However, **I understand that I am primarily responsible for the payment of my bill.**

HIPAA NOTICE OF PRIVACY PRACTICES: I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES ISSUED BY DR.REISS OR DR. PATEL, EFFECTIVE APRIL 14, 2003.

X _____ Date _____

Signature of Beneficiary or Authorized Party