FINANACIAL NOTICE TO ALL PATIENTS

All patients without medical insurance coverage, or those who choose not to use their insurance coverage, will be expected to pay the full examination charge at the time of service.

Any patient with an outstanding balance due is expected to pay the balance in full after the first billing statement. If the balance is not paid in full after three (3) billing cycles, a $25.00 fee will be assessed and the account will be sent to an outside source for collections.

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PATIENT/ GUARDIAN/ INSURED'S SIGNATURE

REFRACTIONS (EXAM FOR GLASSES)

All patients that are new to Milauskas Eye Institute, or that have not been seen in over one year, will have a refraction as part of their comprehensive exam unless they are being seen for an urgent care need. Refractions are not a covered service for Medicare or most other insurance plans, therefore the patient will be responsible for paying the refraction fee. This payment is due at the time of service.

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PATIENT/ GUARDIAN/ INSURER'S SIGNATURE

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Milauskas Eye Institute for any services furnished to me by Milauskas Eye Institute. I authorize any holder or medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or 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. If item 9 of the HCFA-1500 is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is only responsible for the deductible, coinsurance and non-covered charges. Coinsurances and the deductible are based upon determination of the Medicare carrier.

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BENEFICIARY SIGNATURE

HMO & COMMERCIAL PATIENTS

I Herby authorize and request my insurance company to pay directly to Milauskas Eye Institute the amount(s) due on my claim for services rendered to my dependent(s) or to me. I further agree, should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for the difference, and if the services were such that they are not covered by the policy, I will be responsible to Milauskas Eye Institute for payment of the entire bill.

If I do not receive the proper authorization to been seen by Milauskas Eye Institute, I will be responsible for all charges incurred. (Please read your insurance information so that all of the plan requirements are clear to you. Questions should be referred to your health plan.)

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INSURED'S SIGNATURE