VisionFirst Eye Center
First in Total Eye Care

AUTHORIZATION FOR TREATMENT:

By virtue of my signature I authorize VisionFirst Eye Center, Inc. and any of its employees or other authorized personnel or agents to provide general healthcare service to me.

MEDICARE / INSURANCE PAYMENT AGREEMENT:

I request that payment of authorized Medicare / Insurance benefits be made to either me or on my behalf to VisionFirst Eye Center for any services furnished to me by its physicians or suppliers. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurer and its agents any information needed to determine these benefits payable to 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 coverage is indicated in item 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, 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 responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare or other insurance carrier.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):

I acknowledge that I have received a copy of VisionFirst Eye Center's Notice of Privacy Practices. I authorize VisionFirst to release my medical information as follows (except for the necessary release to referring physicians and my insurance company as addressed in RELEASE OF INFORMATION below):

- q Do not leave messages on my answering machine regarding appointment times, insurance information, etc.
- q OK to leave messages on my answering machine regarding appointment times, insurance information, etc.
- q Do not release my health information to anyone other than myself
- q OK to release my health information to any family member
- q OK to release my health information only to the following: _____

RELEASE OF INFORMATION:

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records if necessary.

CHARGES NOT COVERED BY INSURANCE – ADVANCE BENEFICIARY NOTICE

Medicare will only pay for services that it determines to be "Reasonable and Necessary" under Section 1862 (A) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. As your physician, I feel that the service listed below is in your medical interest. I believe that, in your case, Medicare is likely to deny payment for this service for the reason stated below. BCBS of Alabama and other insurance plans may not pay for the following procedure that your physician feels is in your medical interest that it be done.

I have been notified by my physician that he/she believes that, in my case, Medicare or whatever insurance I have is likely to deny payment for the service identified below. If Medicare or my insurance denies payment, I agree to be personally and fully responsible for payment.

Date_____ Service: Refraction Reason: eyeglass prescription check Charge: $25.00

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Patient or authorized signature _____Date _____

Printed name of patient's representative _____

Relationship to patient _____