Signature on File, Assignment of Benefits, Financial Agreement

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to ATLANTIS VISION CENTER/DR LEANN MANDESE, for services furnished me by ATLANTIS VISION CENTER/DR LEANN MANDESE . 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 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 other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. ATLANTIS VISION CENTER/DR LEANN MANDESE accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered 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 CMS-1500 form or elsewhere on other approved claim forms, 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 ATLANTIS VISION CENTER/DR LEANN MANDESE, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** ATLANTIS VISION CENTER/DR LEANN MANDESE may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to ATLANTIS VISION CENTER/DR LEANN MANDESE for reimbursement for services rendered, and (2) any health care provider for continued patient care. ATLANTIS VISION CENTER/DR LEANN MANDESE may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that ATLANTIS VISION CENTER/DR LEANN MANDESE maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that ATLANTIS VISION CENTER/DR LEANN MANDESE has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by ATLANTIS VISION CENTER/DR LEANN MANDESE if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that ATLANTIS VISION CENTER/DR LEANN MANDESE's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with ATLANTIS VISION CENTER/DR LEANN MANDESE to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by ATLANTIS VISION CENTER/DR LEANN MANDESE, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to ATLANTIS VISION CENTER/DR LEANN MANDESE for payment. If an account is sent to an attorney 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 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 insuring the patient, or any other party liable to the patient, is hereby assigned to ATLANTIS VISION CENTER/DR LEANN MANDESE. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to ATLANTIS VISION CENTER/DR LEANN MANDESE. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

Beneficiary Signature or Authorized Party Date

PATIENT FINANCIAL RESPONSIBILITIES

Here at Atlantis Vision Center, we are committed to providing you with the best possible care. To achieve this goal, we need your assistance, and your understanding of our payment policy. Co-pays and deductibles must be paid at the time of service.
I understand that I am ultimately responsible to make payment for all services provided to me by Atlantis Vision Center.
Atlantis Vision Center will add service charges and fees in addition to the face value of any returned checks based on the laws of the State of Florida. These charges begin at $25 but will not exceed 5% of the face value.

Signature_____ **Date**_____