

Permission to File Your Insurance and Receive Payment

Statement to Permit Payment of Medicare and/or Insurance benefits to Provider: I certify that the information given by me in applying for payment under Title XVII or XIX of the Social Security Act is correct, and I request that payment of authorized benefits be made on my behalf. I assign benefits payable to Anderson Eye & Ear Associates, P.A. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers, any information needed for this or a related Medicare / Insurance claim.

Anderson Eye & Ear Associates, P.A. Financial Policy

Patient Financial Policy: At Medicus we provide quality care for our patients. We ask you to understand that you will be expected to pay and are responsible for any charges that are not covered by insurance on the date of service: patient balance, co-pay, deductible, coinsurance or any non-covered services. If there is any disagreement you will need to contact your insurance provider prior to seeing the doctor. We ask your cooperation and assistance in providing us with the information we need from you and in following our financial policy.

- After filing your insurance if we do not receive a response from your insurance company, have been unsuccessful in getting payment, or they request additional information from you, we will send you a statement of your account and letter asking you to follow up with your insurance company.
- Even though we may participate with your insurance carrier, certain services will not be covered by a specific insurance plan. Example: *Vision Services*. Be aware whether or not vision services are covered under your medical insurance or under a separate vision plan. You will need to know this information before seeing one of our doctors. You will be held financially responsible if the insurance does not cover a service.
- There may be times when your account has a credit balance. If the balance is over \$5.00 we will send you a refund. If it below \$5.00 it will remain on your account and applied to any future charges.

Signing this form means I have read, understand, and agree to cooperate with this Financial Policy.

I understand that all charges may not be covered by my insurance plan benefits. If I disagree with a claim denial, it is my responsibility to contact my insurance carrier about their decision.

The address, telephone number, and insurance information given are current and accurate as of today's date.

Signature: _____

Date: _____

Relationship to Patient: _____

Witness: _____

**Patient / Parent / Guardian
Financial Policy Signature**