Drs. Campbell Cunningham Taylor & Haun

EyeCare Optical
A Division of Drs. Campbell, Cunningham, Taylor & Haun

INSURANCE AND FINANCIAL CONSENT

PATIENT NAME: **DOB:** **DATE:**

The Patient or Guarantor is responsible for payment in full of all services rendered by physicians or employees of Drs. Campbell, Cunningham, Taylor & Haun. Payment in full is expected at the time of service unless arrangements are made in advance.

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Drs. Campbell, Cunningham, Taylor & Haun to release to the insurance companies and/or their intermediaries and/or carriers any medical or other information needed for claims reimbursement.

I hereby assign, transfer, and set over to Drs. Campbell, Cunningham, Taylor & Haun all medical reimbursement benefits under my insurance policy with documented insurance companies.

I hereby acknowledge and accept responsibility for payment in full of all non-covered services rendered to me by Drs. Campbell, Cunningham, Taylor & Haun. Should it be necessary to enforce the provisions of this agreement through an attorney or any legal proceedings, the undersigned promises to pay all costs of collection, including reasonable attorney's fee and all court costs.

ASSIGNMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf to Drs. Campbell, Cunningham, Taylor & Haun for any service furnished to me by a physician of the group. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and **I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.**

MEDIGAP OR OTHER SECONDARY AND/OR TERTIARY INSURANCE

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to Drs. Campbell, Cunningham, Taylor & Haun, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer or any information needed to determine these benefits payable for related services. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

_____ _____

DATE SIGNATURE OF PATIENT/GUARDIAN