PATIENT CONSENT & RESPONSIBILITY

Our goal is to provide you with the best medical care available. In order to achieve our goal and minimize escalating administrative costs, we ask for your understanding and cooperation regarding the following payment/ insurance policies:

- We ask that payments be made at the time of your visit unless other arrangements have been made in advance. Our payment policy also requires that payments for refraction are expected at the time of service for all Medicare patients as well as for those patients whose insurance does not cover refraction.
- For cases which we bill the insurance directly, we MUST HAVE A COPY OF THE INSURANCE ID CARD
- If payment is not received from the insurance carrier or other responsible third party in 30 days, we have the right to bill you directly.
- If you are a member of an HMO or PPO plan, you need to have a VALID referral for each office visit and surgical procedure. Please call our office in advance to make sure you have the necessary forms and authorization.

Non- Medicare Patients:

I hereby authorize payment directly to Gerstein Eye Institute of the surgical and/or medical benefits, if any, otherwise payable to me for services as rendered. I authorize the physician to release such medical or other information regarding this treatment or subsequent treatment relative to this injury or illness for the purpose of obtaining reimbursement on my behalf for services provided by the physician, or, to others involved in my care.

Medicare Patients:

I request that payment of authorized Medicare benefits be made on my behalf to Gerstein Eye Institute for any services furnished me by those physicians. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

I request that payment of authorized “Medigap” benefits be made to Gerstein Eye Institute for any services furnished me by those physicians. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physicians as is necessary in his medical judgment.

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payments for annual deductibles and co-insurance may be collected at time of service. I understand that I am financially responsible for charges not covered by my insurance company. I understand that if the office agrees to bill the insurance as a courtesy, I must submit information as needed to ensure payment for the services rendered to me. I understand that I am ultimately responsible for payment of all services. Payments not received within 30 days of billing may be assessed a 5% interest on any unpaid balance. In addition, a collection fee of 20% will be added to any account referred to a collection agency.

Authorization to release Protected Health Information (PHI) and obtain and use Prescription History

I agree to disclose my PHI to the individuals identified below. I authorize Gerstein Eye Institute to release any personal information relating to my health care

To: ____ Relationship to the Patient: ________________________

To: ____ Relationship to the Patient: ________________________

I understand that I have the right to restrict information that may be released, and that this restriction must be in writing. This does not include information regarding this treatment or subsequent treatment relative to this injury or illness for the purpose of obtaining reimbursement on my behalf for services provided by the physician, or, to others involved in my care. (Please initial below)

_____________ No Restrictions

_____________ With Restrictions (list-ex. medication only, appointments, Etc.)___________________________

I agree that Gerstein Eye Institute may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

____
Patient Name Printed

____ ______________
Patient Signature or Responsible Party Date