PATIENT FINANCIAL RESPONSIBILITY

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.
- I understand and agree that my account may be turned over to a collection agency after 90 days and that I will be responsible for an administrative collection charge.
- I understand that it is my responsibility to present all insurances at the time of my visit. If I do not present insurance information for medical and/or vision insurance that I will solely be responsible for payment.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to *Yardley Eye Care, LLC, Dr. Brian Cohen and authorized representatives* on my behalf for any services furnished to me by the providers

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize *Yardley Eye Care, LLC, Dr. Brian Cohen, other providers of Yardley Eye Care and authorized representatives* to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT (This pertains only to Medicare recipients)

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in *Yardley Eye Care, LLC, Dr. Brian Cohen, other providers of Yardley Eye Care and authorized representatives*. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

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Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

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Signature of Patient, Authorized Representative or Responsible Party Date