VISION SOURCE® OF MT. OLIVE

MICHAEL J. SIEGEL, O.D. LIC#OA5118

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Signature on file Authorization and acknowledgement of receipt of Privacy Practices; Statement to permit payment from any insurance carrier including Medicare

- Medicare: I request payment of authorized Medicare benefits to be made on my behalf to Vision Source of Mt. Olive. I authorize 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 or the release of medical information necessary to pay the claims. I am responsible for the annual deductible before Medicare will pay for services. After I meet my deductible, I understand Medicare will only pay 80% of the approved fee. I am responsible for the 20% co-payment plus any other non-covered fees. I understand if I have secondary insurance (AARP, BCBS…), they may pay as long as I provide the insurance information. I understand I will be responsible for these fees after payment is received from Medicare.

- Vision Source of Mt. Olive does not participate in Durable Medical Goods; Medicare will cover some portion of glasses after cataract surgery, however, we cannot provide them.

- Insurance does not usually cover the refraction portion of the eye exam; I will be responsible for this fee.
- Insurance does not usually cover the Optomap retinal examination – I will be responsible for this fee if I want this service.
- Insurance does not usually cover the evaluation or fitting of contact lenses – I will be responsible for this fee.

- I acknowledge and certify that I have insurance coverage (or dependent coverage) and assign directly to Vision Source of Mt. Olive all benefits payable for services rendered. I am financially responsible for all services and fees for the visit. My signature below authorizes any release of protected health information necessary to secure payment of benefits or to determine benefits and acts as signature of file for all claim submissions.

- I understand that all eyeglass orders are custom and are non-refundable once submitted.
- I understand that there is a charge of $50.00 for missed appointments without giving at least a 48 hours notice.
- I understand that if a balance on my account is not paid in full after 90 days, a collection fee of $50 or 40% of the balance (whichever is greater) can be added to the account.

- **I authorize Vision Source of Mt. Olive to leave messages at the following: Home phone Cell phone Email**
  (Please circle the ones that you will allow and want to be notified by)

- I acknowledge that I received a copy of Vision Source of Mt. Olive's Notice of Privacy Practices.
- This signature on file and assignment of benefits will remain in effect until revoked by me in writing. A photocopy or electronic copy of this assignment is to be considered as valid as an original.

I have read and understand the above information.

Patient Name (print) _____

Patient/Guardian Signature_____Date_____