

Signature on File, Assignment of Benefits, Financial Agreement

Patient Name (please print) _____

I authorize my medical insurance company or any private or government medical plan or medical benefit payer to pay medical benefits directly to Sanford G. Feldman M.D., Inc./Ellie Samadani M.D./ Patricia Bainter M.D. and/or One to One LASIK for medical services and/or supplies.

Patient or Guardian Signature

Date

I understand that Sanford G. Feldman M.D., Inc./Ellie Samadani M.D./Patricia Bainter M.D. may release my medical or other information for the purpose of processing my claim for insurance benefits or as required by governmental regulation or for continuing care by another physician.

Patient or Guardian Signature

Date

POLICY ON PRIOR AUTHORIZATION

It is the patient's responsibility to notify this office if your primary or secondary insurance plan requires prior authorization before services are rendered. **You are fully responsible for all charges that your medical plan does not reimburse because of the failure to obtain proper authorization.**

Have you obtained prior authorization from Primary Insurance? Yes No Not Required

Have you obtained prior authorization from Secondary Insurance? Yes No Not Required

Name of Primary Care Physician

Primary Care Physician's Phone Number

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Payment for all professional services rendered is the responsibility of the patient. We will file an insurance claim on your behalf. However, even though an insurance claim is filed, you will receive a statement after 60 days if your account has a balance due. You are responsible for all charges for the services or medical supplies not paid by your insurance carrier within 60 days of the date of service, subject to the conditions of the contract with your insurance company or government regulations.

I understand I am financially responsible for all charges incurred by me which are not satisfied by my insurance company. This includes any deductible or co-payment and any charges for services not covered by insurance. I further agree that if I fail to pay any of the charges for which I am responsible, I will be liable for all reasonable collection costs, including but not limited to court costs and attorney's fees if legal action is necessary.

Signature of financially responsible person

Date

Printed Name