**Consent for Assignment of Benefits and Financial Agreement**

I authorize that payment of authorized Medicare, Medigap, Medicaid or any other insurance be made on my behalf to Milan Eye Center for any services furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and other insurers and it’s agents any information needed to determine benefits payable for related services.

I authorize Milan Eye Center and third-party collection agents to utilize all contact information I have provided to communicate with me. This includes, but not limited to, home telephone, cellular telephone, and employment telephone. I grant consent for Milan Eye Center and third-party collection agents to leave voice and/or text messages on my home telephone, cellular telephone, and employment telephone.

I understand that Milan Eye Center maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and I understand that Milan Eye Center has no contract, expressed or implied, with any plan that does not appear on the list. I understand that I am obligated to pay the full charges of all services rendered to me by Milan Eye Center if I belong to a plan that does not appear on the above-mentioned list. I understand that Milan Eye Center contracts with health care service plans that specify items and services which are “covered” by the health care service plans. Accordingly, I accept full financial responsibility for all items or services which are determined by the health care service plans not to be covered. I understand that it is the policy holder’s responsibility to determine what services are covered and not covered by the insurance plan.

I understand that if my health care plan requires an insurance referral to see a specialist, that I am responsible for obtaining the documentation prior to my appointment at Milan Eye Center.

I agree that in return for the services provided by Milan Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Milan Eye Center for payment. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Milan Eye Center at the time of service. If an account is sent to an attorney for collection, I agree to pay collection expenses. A $25 fee may be applied for any returned checks.

**Minor Patients**

The adult accompanying a minor and/or the parents or guardians are responsible for the full payment when services are rendered. For unaccompanied minors, non-emergency treatment will be denied.

**Power of Attorney**

For Patient Safety and compliance regarding patient care, we require any patient who is seen at our facility through a nursing home, rehab center, or assisted living facility to have their Power of Attorney present for their visit. Without a POA present, we will not be able to see you at your scheduled appointment.

**Medical Records**

Medical records are available upon request. A release must be signed by the patient and photo ID must be presented at time of pick-up.

**Self-Pay Patients**

For patients who do not have insurance, we do offer a self-pay rate for services. We require a minimum of $200 upon check-in at your visit. Any additional cost for the visit will be due at time of check-out.

**Financing Options**

We have several financing options available. Such options include Care Credit, Wells Fargo, and Alphaeon. Please contact our business office for details.

**By signing, I understand and acknowledge the above policies.**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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