EASTSIDE EYE SURGEONS PLLC

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

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Patient Name

MEDICARE PATIENTS: I request that payment by Medicare be made on my behalf to Dr. Mandelbaum/ Dr. Borodkin/ Dr. Barasch for services furnished to me by Dr. Mandelbaum/ Dr. Borodkin/ Dr. Barasch. I authorize my medical information about me to be released to Medicare and its agents and information needed to determine payable benefits. Dr. Mandelbaum/ Dr. Borodkin/ Dr. Barasch accepts the charge determination of the Medicare carrier as full payment. I am responsible for deductibles, co-payments and non covered services.

MEDIGAP PATIENTS and/or SECONDARY INSURANCE (AARP, BLUE SHIELD, EMPIRE, GHI, ETC.)
I understand that if I have secondary health insurance they will be billed after my primary insurance has paid. If Dr. Mandelbaum/ Dr. Borodkin/ Dr. Barasch do not participate with my secondary insurance I am responsible for any balance due as well as deductibles, co-payments and non-covered services.

OTHER INSURANCE (OXFORD, AETNA, ETC.)
Dr. Mandelbaum/ Dr. Borodkin/ Dr. Barasch maintain a list of health care service plans with whom they are contracted. If they are contracted with my plan, that insurance will be billed directly. I am responsible for any deductible, co-pay or co-insurance for non-covered services at the time services are rendered.

NON-COVERED SERVICES:
I understand that I am responsible for any non-covered services and accept full responsibility for all items and services if considered **"not covered"** by my insurance plan. THIS COULD INCLUDE BUT IS NOT LIMITED TO; REFRACTION, DIAGNOSTIC TESTING, TREATMENT AND OTHER SERVICES.

RELEASE OF INFORMATION:
Dr. Mandelbaum/ Dr. Borodkin/ Dr. Barasch may disclose all or any part of my medical record and/or financial record which is necessary or appropriate in order to bill my insurance company. A copy of this signed authorization may be used in place of the original.

FINANCIAL AGREEMENT:
I agree that in return for the services provided to the patient by Dr.Mandelbaum/ Dr. Borodkin/ Dr. Barasch, I will pay my account at the time services are rendered. If my account is sent to an attorney or collection agency, I agree to pay any expenses or attorney's fees, in addition to the past due account. I understand that if my account is delinquent I may be charged interest at the legal rate. It is understood that the undersigned and/or patient is the primary responsible person for the bill regardless of insurance.

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Signature of Patient or Authorized Person Date