MID-AMERICA EYE CENTER, P.A.

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (please print) _____ Medicare Number (if applicable) _____

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Mid-America Eye Center for services furnished me by Mid-America Eye Center. I authorized any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Mid-America Eye Center accepts the charge determination of the Medicare carrier and as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claims forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Mid-America Eye Center, if possible, or otherwise to me.

3. OTHER INSURANCE: I understand that Mid-America 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. Mid-America Eye Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Mid-America Eye Center if I belong to a plan that does not appear on the above mentioned list. ***Some insurance plans require that a referral must be obtained from a primary care physician. The patient must acquire this referral prior to any office visit or surgery. This is a patient responsibility, and the patient will be held responsible for any and all balances due from failure to obtain a referral.***

4. NON-COVERED SERVICES: I understand that Mid-America Eye Center's contracts with health care plans (i.e., HMOs, PPOs, Missouri and Kansas Medicaids) relate only to items and services, which are "covered" by the health care service plans. Accordingly, the undersigned accepts full responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. **Refraction (92015) is not a covered service and is the patient's responsibility.** The undersigned agrees to cooperate with Mid-America Eye Center to obtain necessary health care service plan authorizations.

5. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Mid-America Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Mid-America Eye Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Mid-America Eye Center. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

6. OWNERSHIP: The following physicians own interest in Physician's Surgery Center: Dr. Joseph J. Parelman, MD and Steven R. Unterman, MD.

Beneficiary Signature or Authorized Party _____ Date _____

Revised 5/18/2009