ANEW VISION
EYE SPECIALISTS

Authorization of Payment

Medicare/Private Plans:

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Anew Vision Eye Specialists (AVES), for services furnished me by the providers at AVES. 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 benefits payable to related services. I understand my signature requests that payment be made and authorizes releases of medical information necessary to pay the claim.

AVES accepts the charge determination of the Medicare or other carrier, as the full charge, and the patient is responsible for the ***deductible, coinsurance, copay and non-covered services.***

Coinsurance, Copay and Deductibles are based upon the charge determination of the Insurance carrier.

Coinsurance/Private Insurance:

If a second policy or other health insurance is indicated, I hereby authorize payment of my medical and surgical insurance benefits to AVES. I understand I am ***financially responsible for any charges whether or not paid by said insurance***. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to AVES. I authorize AVES to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of my original signature.

Authorization to release

I hereby authorize AVES to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

Assignment of insurance benefits

I hereby assign to AVES all reimbursement to which I am entitled for expenses relative to the services performed from time to time, but not to exceed my indebtedness to AVES. I understand that I am financially responsible to AVES for charges for all the **charges for all services** rendered. I understand that if I do not pay my bills, I will be charged a yearly interest plus all collection charges.

Patient Name (Print) _____

Signature _____ **Date** ____/____/_____