Lewis County
Eye & Vision Associates, P.S.

Acknowledgment of Receipt of Privacy Policies (HIPAA):

- I acknowledge that I received a copy of the Notice of Privacy Practices for this office (In Office).

Consent to Treat:

- I hereby give my permission to Lewis County Eye & Vision to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment.

Insurance Authorization:

- I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to Lewis County Eye & Vision.
- I authorize any holder of medical information about me to release to my insurance company and its agents any information needed, including third party payers, to determine these benefits or the benefits payable for related services.
- I understand that I am responsible for charges not paid by the insurance plan.
- I understand that I am financially responsible for any remaining balance.

Beneficiary Agreement for Medicare Patients:

I have been notified by my physician that Medicare is likely to deny payment for the services identified below for the reasons stated. I agree to be personally and fully responsible for payment if Medicare denies payment. I understand that, by law, the physician is obligated to bill me for uncovered services.

- Medicare pays for 80% of **covered** services after your deductible is met.
- Medicare does not pay for the refraction portion of an eye examination. Visual fields testing may also not be covered.
- Medicare does not pay for frames or lenses unless the patient has undergone cataract removal surgery. Lens coatings, tints, or other extras above basic bifocals or trifocals may not be covered.
- Routine eye exams are not covered.

Patient Signature on File Card Lifetime Authorization:

- I request that payment of authorized Insurance benefits (including Medicare benefits) for any services furnished me, be made on my behalf to Lewis County Eye & Vision.
- 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 for related services.

After reviewing the preceding information, please sign here that you acknowledge and understand.

Patient/Guardian signature: _____

Date: _____

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