MECA
Munster Eye Care Associates, P.C.
Comprehensive Ophthalmology/Optometry and Optical Dispensary
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munstereyecare.com

Consent to Medical Treatment, Signature on File, Assignment of Benefits, Financial Agreement and HIPAA Notice of Privacy Practices

Beneficiary Name (print) _____ Account Number _____

I, the undersigned, being the person whose name appears hereafter designated as the "patient" or being a person legally authorized to consent to services on behalf of the patient, do hereby voluntarily consent and authorize Munster Eye Care Associates, P.C. (MECA) and its agents to administer any treatment which may be deemed necessary and advisable for the diagnosis and treatment of the patient including: medical care, surgical care, diagnostic tests, procedures, drugs and other services that may be advisable for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by MECA, nor have I relied upon any such representations, warranties, or guarantees.

1. **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to MECA for services furnished me by MECA. I authorize any holder of medical information about me to release to the Centers 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 CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. MECA accepts the charge determination of the Medicare carrier 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 CMS 1500 form or elsewhere on other approved claim 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 MECA, if possible or otherwise to me.

3. **Release of Information:** MECA may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to MECA for reimbursement for services rendered, and (2) any health care provider for continued patient care. MECA may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

4. **Other Insurance:** I understand that MECA maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that MECA 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 MECA if I belong to a plan that does not appear on the above mentioned list.

5. **Non-Covered Services:** I understand that MECA's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial 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. The undersigned agrees to cooperate with MECA to obtain necessary health care service plan authorizations.

6. **Financial Agreement:** I agree that in return for the services provided to the patient by MECA, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to MECA for payment. If an account is sent to an attorney for collection, I agree to pay collection 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, is hereby assigned to MECA. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to MECA. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

7. **HIPAA:** I acknowledge that I have been given the opportunity to review and/or receive Notice of Privacy Practices put forth by Munster Eye Care Associates, P.C. / Form 7.20 – Publication Date 07/16/2013.

This assignment will remain in effect until revoked by me in writing. A photocopy of this consent for treatment, signature on file, assignment of benefits and financial agreement is considered to be as valid as the original.

Electronic Signature Required Upon Arrival

Beneficiary Signature or Authorized Party _____ Date