

SIGNATURE ON FILE

\_\_\_\_\_  
Beneficiary's name

\_\_\_\_\_  
Medicare Identification Number

**Medicare**

I request that payment of authorized MEDICARE benefits be made on my behalf to ADVANCED OPHTHALMOLOGY INSTITUTE and/or Mihir Parikh MD, Inc. for services furnished to me by the practice. 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 that 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 GCFA 1500 Form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

ADVANCED OPHTHALMOLOGY INSTITUTE and/or Mihir Parikh MD, Inc. accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Medigap**

If Medigap policy or other health insurance is indicated in Item 9 of the HCFA 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 either to me or on my behalf to ADVANCED OPHTHALMOLOGY INSTITUTE and/or Mihir Parikh MD, Inc.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Other Insurance**

Insurance Company Name \_\_\_\_\_

I hereby authorize payment of my medical and surgical insurance benefits to ADVANCED OPHTHALMOLOGY INSTITUTE and/or Mihir Parikh MD Inc. I understand that I am financially responsible for any and all charges whether or not paid by said insurance, or if I am not eligible for these services at this time. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the practice. I authorize ADVANCED OPHTHALMOLOGY INSTITUTE and/or Mihir Parikh MD, Inc. 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 the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_

I authorize my medical insurance company or any private or government medical plan or medical benefit payer to pay medical benefits directly to ADVANCED OPHTHALMOLGY INSTITUTE and/or Mihir Parikh MD, Inc. for medical services and/or supplies. I understand that ADVANCED OPHTHALMOLGY INSTITUTE and/or Mihir Parikh MD, Inc. may release my medical or other information for the purpose of processing my claim for insurance benefits.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

**Policy On Prior Authorization**

It is the patient's responsibility to notify this office if you primary or secondary insurance plan requires prior authorization before services are rendered. You are fully responsible for all charges that your medical plan does not reimburse because of the failure to obtain proper authorization.

Have you obtained prior authorization from Primary Insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Not required

Have you obtained prior authorization from Secondary Insurance? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Not required

\_\_\_\_\_  
Name of Primary Care Physician/Phone number

\_\_\_\_\_  
Date

**Policy Concerning Payment of Medical Bills**

Payment for all professional services rendered is the responsibility of the patient. We will file and insurance claim on your behalf. However, even though an insurance claim is filed, you will receive a statement after 60 days if your account has a balance due. You are responsible for all charges for services or medical supplies not paid by your insurance carrier within 60 das of the date of service, subject to the conditions of the contract with your insurance company or government regulations.

I understand I am financially responsible for all charges incurred by me which are not satisfied by my insurance company. I further agree that if I fail to pay any of the charges for which I am responsible, I will be liable for all reasonable collection costs, including but not limited to court costs and attorney's fees if legal action is necessary.

\_\_\_\_\_  
Signature of financially responsible person

\_\_\_\_\_  
Date