MALBAR VISION

Malbar Vision Center

INSURANCE AUTHORIZATION / PAYMENT AGREEMENT

I authorize payment of medical benefits to Malbar Vision Center for services ren-dered. I also authorize Malbar Vision Center, its physicians, employees, and agents to release medical information to insurance companies, third party payers as is necessary for completion of insurance claims, determination of benefits, and related items.

I have read and understand the above information. I understand I am responsible for payment of any insurance deductibles, co-payments, or services and materials not covered by my insurance. My signature on this form will serve as a "Signature On File" for processing claim forms.

Patient Name (please print) _____

Patient Signature (parent if minor) _____

Date _____ **Social Security #** _____

MEDICARE GUIDE FOR EYECARE

GENERAL RULES

You must pay the annual deductible toward any qualified health care before Medicare will pay for any services. After you meet your deductible, Medicare will pay 80% of the doctor's "approved fee". You will pay 20% as a co-payment, plus any non-covered fees.

If you have supplemental insurance (such as Blue Cross / Blue Shield), it may cover the cost of the deductible and co-payment.

Our office will bill Medicare and accept payment directly from them if the services qualify for coverage (see exceptions below). You are responsible for paying any non-covered services at the time of your office visit.

SPECIAL EXCEPTIONS

- Medicare does not cover eyeglasses or contact lenses except for the first lenses following cataract surgery.
- Medicare does not cover the refraction part of the eye exam.
- Medicare may deny benefits if it feels you are receiving examinations too frequently or receiving exams by more than one doctor for the same illness.

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Today's Date_____

Patient's Name _____
First (Given Name) Middle Last Name you prefer to be called

Mailing Address _____ City _____ State_____ Zip _____

Phone (___)_____ Cell Phone (___)_____ E-mail _____

Date of Birth_____ Age_____ ❑ Male ❑ Female Social Security #_____

If form is being completed for an adult, please complete the following information:

Occupation _____

Employer _____ Business Phone (___)_____

If married, name of spouse _____ Spouse's occupation _____

Employer _____ Business Phone (___)_____

If form is being completed for a dependent, please complete the following information:

If patient is a student: Grade or Year in School _____

Father's Name _____ Social Security #_____

Address (if different from patient) _____

Occupation _____ Employer _____

Business Phone (___)_____

Mother's Name _____ Social Security #_____

Address (if different from patient) _____

Occupation _____ Employer _____

Business Phone (___)_____

Emergency Contact Person (Not living in your household) _____

Daytime Phone(___)_____ Relationship _____

Have you or any member of your immediate family been a patient of International Eyecare Center?

If yes, please name_____

To help our office keep more accurate records, please list any other immediate family members living at home and their ages _____

How were you referred to our office? Friend or Relative (Please name)_____

Newspaper ___ TV ___ Direct Mail ___ Yellow Pages ___ Radio ___ Sign ___ Sightsaver, Plus! ___ Word of mouth ___

If you have Medicare, Insurance or a special vision plan, please read and sign the form on the reverse side of this paper and have your card(s) ready to copy.

Payment Policy: Full payment is due at the time service is rendered. We accept cash, check, Visa/MasterCard/Discover.