



Scott W. Beeve, M.D.
General Ophthalmology
LASIK & Cataract Surgeon

Jerold E. Beeve, M.D. F.A.C.S
A California Medical Corporation
Eye Physician & Surgeon
Diplomat, American Board of Ophthalmology

EYE SURGICAL & VISION CARE CENTER

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

Beneficiary Name (Print)

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **Jerold E. Beeve/Scott W. Beeve M.D., Inc.**, for services furnished to me by **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's 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 HCFA 1500 form or elsewhere on the other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** 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 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 on my behalf to **Jerold E. Beeve/Scott W. Beeve M.D., Inc.**, if possible or otherwise to me.
3. **RELEASE OF INFORMATION:** **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** 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 **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** 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, status, or regulation.
4. **OTHER INSURANCE:** I understand that **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** 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 **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** has no contract, expressed or implied, with any 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 **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** if I belong to a plan that does not appear on the above-mentioned list.
5. **NON-COVERED SERVICES:** I understand that **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** contracts with health care service plans (i.e., HMO's, PPO's) state items and services, which are "covered" by the health 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 plan furnishes to the patient; and treatment or test not authorized by the health care service plan. The undersigned agrees to cooperate with **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by **Jerold E. Beeve/Scott W. Beeve M.D., Inc.**, I will pay my account at the time of service is rendered or will make financial arrangements satisfactory to **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** as 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 maybe 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 **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Jerold E. Beeve/Scott W. Beeve M.D., Inc.** **However, it is understood that the undersigned and/or the patient is primarily responsible for the payment of my bill.**

X _____
Signature of Patient/Guardian or Responsible Party

_____/_____/_____
Date