INSURANCE & PAYMENT

Version 09.24.2015

HEALTH INSURANCE CARRIER(S)

PRIMARY:_____ **SECONDARY:**_____

VISION INSURANCE CARRIER(S)

PRIMARY:_____ **SECONDARY:**_____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW:

I request payment of authorized Medicare, Medicaid or other insurance carrier's benefits be made on my behalf to Williamson Allemond Regional Eye Center for any services furnished. I authorize the holder of medical information to release to the Health Care Financing Administration and its agents, and any other authorized insurance carrier, information needed to determine these benefits or the benefits payable for related services.

There are some services that Medicare, Medicaid and most other insurance carriers **Will Not Pay For**. In these cases I may be responsible for the remaining balance on my account. These fees **Plus** any co-payments or deductibles are **Due At The Time Of Service**.

I have read and understand this information.

PATIENT SIGNATURE (OR REPRESENTATIVE): _____**DATE:**_____

FINANCIAL AGREEMENT

I understand that payment is due at the time of service. I agree to pay for all past due balances that were unpaid by my insurance company from previous visit and/or treatment. This includes: copays, coinsurance, deductibles or any other non-covered charges for medical care. If I do not have medical insurance, I understand that it becomes my responsibility to make financial arrangements prior to the medical services rendered. I further authorize third parties to pay directly the **Williamson Allemond Regional Eye Center** any insurance benefits due for services rendered on my behalf or the named patient that I am a guarantor for. I hereby assign all medical and vision benefits to include major medical benefits and vision plan benefits to which I am entitled, including Medicare, Medicaid, private insurance policies and other related health and/or vision plans to the **Williamson Allemond Regional Eye Center.**

I agree to notify the **Center** of any changes in insurance, changes in my address or in the case of any other changes to information included in my demographic or registration paperwork. I understand that I am responsible for all charges not paid by my insurance carriers. If it becomes necessary to collect any sum of money due through the use of a collection agency or attorney, then I agree to pay all reasonable costs of collection proceedings and attorney's fees, whether a suit is filed or not. Additionally, I agree to pay court costs associated with such collection efforts as well. I understand that I am responsible for verifying that my providers participate with my insurance plan and that I must present my insurance cards at each office visit.

PATIENT SIGNATURE (OR REPRESENTATIVE): _____**DATE:**_____