Ophthalmology Associates
Jerry B. Cotner, MD
Rishav Kansal, MD

PATIENT FINANCIAL AGREEMENT

☐ INSURANCE ASSIGNMENT AND PATIENT RESPONSIBILITY

The person signing below agrees, whether he/she signs as patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Ophthalmology Associates at the regular rates and terms of Ophthalmology Associates. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment and/or supplies furnished the by the physicians and staff of Ophthalmology Associates for whom Ophthalmology Associates is authorized to bill. I understand that I am responsible for any health insurance deductible, coinsurance and non-covered services <u>at the time services are rendered</u>."

☐ MEDICARE AND/OR MEDICAID CERTIFICATION

The person signing below certifies that he/she has read this document, and is the patient or is duly authorized by the patient as the patient's representative, to execute the above and accepts its terms.

"I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries/carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf."

Relationship to Patient: ☐ Self ☐ Child ☐ Dependent ☐ Other _____

_____	_____	_____
Printed Name	Signature	Date
Printed Name of Witness	Signature of Witness	Date

ASSIGNMENT OF BENEFITS:

In consideration of services rendered, I hereby assign to Ophthalmology Associates and/or any physician who has treated me, all rights, title, and interest in any payment due for services described herein as provided in the policy or policies of insurance. I agree to pay the charges of Ophthalmology Associates, which are greater than the amount paid by the insurance company or companies.

_____	_____	_____
Printed Name	Signature	Date