MEMBER CONSENT FOR FINANCIAL RESPONSIBILITY FOR ALL COMMERCIAL AND GOVERNMENTAL INSURANCES WITH OR WITHOUT AN ANNUAL DEDUCTIBLE, COINSURANCE, & COPAYMENT

1. I understand that my insurance plan requires an upfront co-payment at the time of every visit.
2. I understand that if I have an annual deductible and coinsurance on my plan that does not cover 100% of an office visit and diagnostic/surgical procedure, I agree to be financially liable for the remaining amount not covered by my insurance plan.
3. I understand that if I have Medicare coverage, Medicare has an annual deductible of $183 that I have to meet, and Medicare is only an 80% coverage plan. I am responsible for any payments incurred for the services I receive (unless my secondary insurance plans covers for the annual deductible and coinsurance) and if I do not have a secondary insurance I am responsible for the $183 annual deductible and coinsurance for the remaining 20% not covered by Medicare.
4. I understand that if my plan requires a referral from my PCP to see a specialist and I fail to obtain said referral, I will be held responsible for payment for the provider's FULL CHARGES for all services provided to myself and/or my dependent(s).

   i. Patient responsibility that is assigned by your insurance policy is due at the time of treatment and/or service rendered.

   ii. Changes in insurance policy, whether it is changes in your group number or changes in your insurance carrier should be informed as soon as possible.

   iii. Changes of home address, phone number, and work numbers should be notified promptly.

   iv. Appointments missed, broken or cancelled within 24 hours will be subject to a cancellation charge of $25. Please plan ahead and make sure to inform us at least 24 hours before if you cannot keep an appointment to avoid unnecessary charges in your account.

   v. If your check payment is returned for insufficient funds from your bank, there will be a 'bounced-check' fee of $35. Unpaid balance aged more than 30 days will be subject to a 3% late charge to the balance.

   vi. An open account over three months with unpaid balance may be subject to collection action. Once the account is sent to our collection agency, we may not accept you as an active patient. You may request release of medical records when a full payment is made to the collection agency.

   vii. If your account goes into collection you will be responsible for any and all charges incurred including but not limited to: prior balance, interest charges and collection fees. Future appointments will be at our discretion.

   viii A billing fee of **$25.00** will be added to your account for any balances **over 31 days** as a late fee that we must attempt to collect through mailing monthly statement.

   ix An "outstanding balance" charge of 15% of the total bill will be charged each month that the bill remains unpaid.

MEMBER CONSENT FOR DILATING EYE DROP

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much of your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you can make arrangements not to drive yourself. Otherwise, you may need to wait until the pupils undilate.

I hereby authorize the doctors and staff at Edison Ophthalmology Associates, LLC to administer dilating eye drops in all my visits as they deem appropriate. If I don't want dilation on specific exam date(s), I will inform the doctor/staff of my intention. The eye drops are necessary to diagnose my condition.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Edison Ophthalmology Assoc. LLC for all insurance benefits otherwise payable to me for services rendered. **I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE, AND I AM FULLY RESPONSIBLE FOR ALL MY CHARGES, WETHER OR NOT PAID BY INSURANCE, AND FOR ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.** I authorize the above doctor and/or provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
REVOCATION: I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELATION TO THIS AUTHORIZATION FOR THE PURPOSES STATED ABOVE. I FURTHER RELEASE MY PHYSICIAN FROM ANY LIABILITY FROM THE RELEASE OF INFORMATION TO THE INDIVIDUAL(S) AGENCY DESIGNATED HEREIN.

Patient (or person authorized to sign for patient): __________________ Date: ___________________