Assignment of Benefits, Financial Agreement, Consent to Treatment, Consent to Communication & HIPAA Acknowledgement

METROLINA EYE ASSOCIATES
A Clear Vision of Excellence

Patient Name:_____
DOB:_____ Chart #:_____

Assignment of Benefits and Authorization to Release Medical Information for Insurance Processing

I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under any of my insurance carriers to the rendering provider of services or supplies furnished to me. I authorize Metrolina Eye Associates (from this point forward, identified as MEA) to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my insurance company does not pay MEA directly, I agree to forward all insurance payment(s) which I receive for the services/supplies rendered by MEA. I authorize MEA or any holder of medical information about me, to release information to my health insurance provider as needed to determine benefits or payment of benefits/services.

Guarantee of Payment

Filing Insurance & Self Pay: I understand that MEA will file claims for services/supplies rendered on my behalf to my insurance company, given that they are a participating provider contracted to file such claims. I understand that MEA will bill me for the remaining portion of my incurred balance, if any, once all insurance claims have been submitted and paid. I understand that I am financially responsible for any services/supplies not covered by insurance for any reason whatsoever including but not limited to: Deductible, Co-pay, Co-insurance, or Non-medically necessary services. I understand that if pre-knowledge of these fees is in place at the time of services/supplies, such fees are expected to be satisfied prior to service/supplies being rendered. If the insurance information I provide to MEA is inaccurate or not effective at the time of service, I will be responsible for payment in full. I understand that should I not have insurance coverage for services/supplies rendered, I will be considered self-pay and will be fully responsible for services/supplies rendered. I understand and agree that pre-payment for such anticipated services/supplies is expected prior to services/supplies being rendered. Over payment will be refunded via check separate of the date of service. Under payment must be satisfied before departure on the date of service.

Account Balances: After insurance claims have been processed and/or paid, any remaining balance is my responsibility and shall be paid in full within the time frame reflected on the MEA statement. All outstanding balances must be satisfied for continued services/supplies to be rendered unless, an approved payment plan has been arranged between myself and MEA and is being upheld by me according to the arrangement terms. Returned check fees or insufficient funds denial for payments made towards MEA will result in an additional $35 fee being assessed to my account and will be expected to be paid in full along with the account fees already incurred within ten calendar days of being notified of this occurrence. A situation as such will also result in the only payment methods accepted from me going forward, to be cash, money order or credit card.

Refractions: A refraction is the test performed to determine the corrective lens power needed to provide best corrected visual acuity. This test however, is not covered by most insurance companies and will be collected in full when this service/test is performed and utilized for the purchase of corrective lenses. I understand that the current fee for this test is $59, I am fully responsible for this fee and it and may change at any time, without notice. I further understand that failure to pay outstanding debts will result in collection actions.

Consent to Treatment

As a MEA patient, I voluntarily consent to the rendering of such care and treatment as MEA providers and personnel, in their professional judgement, deem necessary for my ophthalmic health and needs. Informed consent shall be agreed upon and collected, for services outside of the medical or vision exam, diagnostic testing and usual service(s) rendered. If a request for a telehealth visit ("virtual visit") is made by either party, myself or MEA, I hereby consent to participate in such telehealth visit and its recording in my electronic health record. I further consent to these services being filed to my insurance company, if applicable, or that such costs would be my responsibility.

Consent to Call, Email &/or Text

I understand and agree that MEA may contact me using automated calls, person-to-person calls, emails and/or text messaging sent to the phone number(s) I have provided for myself. These communications may notify me of upcoming appointment information, test results, treatment recommendations, medication details, outstanding balances or any other communications from MEA. I understand the importance in on-going care and communication this consent will provide for myself and my eye care provider. Should I elect to opt-out of communication method(s), I am to inform MEA staff of such decision.

HIPAA

I understand that MEA's printed Privacy Policy/Notice is available at any time by my request to any MEA staff member. Furthermore, the HIPAA contacts listed on my account, given by myself, are the only individuals that have permission to be informed about my account information, chart details or treatment information aside from the Assignment of Benefits policy aforementioned in regards to filing insurance. Verbal and written notice of my elected, HIPAA approved contacts are listed below and are to be placed on my electronic health record:

Name	**Relationship**	**Phone # (optional)**

I hereby acknowledge that I have read and understand this document. Questions, if any, were answered and explained to me by the staff of Metrolina Eye Associates (MEA).

✖ _____ _____

Signature of Patient or Parent/Legal Guardian/Authorized Representative | Relationship to Patient (if applicable)

_____ _____

Witness of Signature (MEA staff member) | Date of Signing