Assignment of Benefits &
Patient Financial Responsibility

Seidenberg Protzko Eye Associates and Mid-Atlantic Surgery Pavilion

PATIENT NAME: _____

DATE OF BIRTH: _____

I request that payment of authorized Medicare and/or my other insurance carrier(s) benefits be made on my behalf to Seidenberg Protzko Eye Associates and/or Mid-Atlantic Surgery Pavilion for services provided to me by Seidenberg Protzko Eye Associates and/or Mid-Atlantic Surgery Pavilion or any physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents and/or my other insurance carrier(s) any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare contractor.

I also request that the payment of any authorized Medigap benefits or other secondary insurance be made on my behalf to Seidenberg Protzko Eye Associates and/or Mid-Atlantic Surgery Pavilion or any physician of that group, for services provided to me. I authorize any holder of medical information about me to release to my Medigap insurer or other commercial payer (where applicable) any information needed to determine these benefits payable for related services.

- I agree to provide all referrals as required by my insurance carrier(s).
- I understand I am responsible for any deductible, co-pay, co-insurance and/or any non-covered services. Co-pays must be paid at the time of service.
- I recognize my responsibility to guarantee the accuracy of the insurance information I have provided. I agree that all claims that are not paid within 60 days as a result of incorrect insurance information provided by me (not errors on part of provider claim submission) will become my financial responsibility.
- I understand any unpaid balances and non-covered services are my financial responsibility. I understand that if I do not make monthly payments on my balance, my account will be sent to a collection agency.
- I understand I will be charged a $14.00 fee for any returned check.*
- I understand that all cosmetic services must be paid at the time of service.
- I understand that all contact lens services must be paid at the time of service.
- I understand that if I do not have insurance, I must pay at the time of service.
- I understand that if I request a glasses prescription during a medical eye exam, I will be charged a $40 refraction fee that must be paid at the time of service.*
- I understand that there will be a $30 fee for the completion of various forms such as FMLA/disability forms and MVA forms.*

SIGNATURE: _____

DATE: _____

*fees subject to change