FINANCIAL AGREEMENT, SIGNATURE ON FILE ASSIGNMENT OF BENEFITS, NON-COVERED SERVICES

1. MEDICARE I request the payment of Medicare benefits be made to Grand View Ophthalmology (GVO) for services provided to me by GVO. I authorize GVO to release medical information about me to CMS and its agents as needed to determine these benefits. I understand that my signature requests that payments be made and authorizes the release of medical information about me needed to pay the claim. My signature also authorizes release of my health information to other health insurance plans for which I have provided coverage and billing identification numbers to Grand View Ophthalmology, and authorizes those insurance plans to make payment to GVO or Dr. Stock on my behalf. GVO accepts the charge determination of the Medicare carrier as the full charge, and I accept responsibility for the deductible, co-insurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. PRIVATE INSURANCE &/or MEDIGAP I request that payment of insurance benefits be made to Grand View Ophthalmology (GVO) on my behalf and authorize GVO to release my health information to my insurance carriers as needed to determine benefits. I realize that many insurance companies require prior authorization from my primary care physician, and that providing such authorization, at each office visit, if necessary, is my responsibility. If my insurance does not authorize services, including office visits, tests and surgical procedures, I agree to be personally responsible for all charges for services provided by GVO. My signature is valid indefinitely unless revoked in writing.

3. Release of information Grand View Ophthalmology (GVO) may use and disclose any or all of my medical record, including information about substance abuse, psychiatric illness, infectious diseases (including HIV) or any other medical condition, and financial records regarding my transactions with GVO to legal entities which are liable to or under contract to GVO for payment for services rendered. Medical records may be disclosed to health care providers if necessary for continued patient care. A copy of this authorization may be used in place of the original.

4. NON-COVERED SERVICES I understand that my insurance plan may not cover all services that are necessary components of my treatment plan. I accept full financial responsibility for all services which my plan determines to be non-covered services. Refraction (measurement for glasses $25.00) is an example of a non-covered service. Cosmetic surgery, treatment and tests not authorized by my insurance plan are non-covered services.

5. PAYMENT POLICY I agree to pay for medical services provided to the patient by Grand View Ophthalmology at the time services are rendered. In lieu of payment I request that payment of insurance benefits be made to Grand View Ophthalmology, PLC. I agree to pay co-payments and refraction charges on the day they are incurred. I realize that Grand View Ophthalmology is providing an additional service by billing my insurance provider as a courtesy to patients and that the patient or guardian is ultimately responsible for payment for service.

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Beneficiary Signature or Authorized Party Date