Bedford Vision & Eye Clinic, PLLC

PATIENT RESPONSIBILTY

Dr. Kathy L. Shamblin, Dr. Kay H. Gregory, and Dr. Kelly A. Sanderson

1. **Individual's Financial Responsibility**
   - I Understand that I am financially responsible for my health insurance deductible, co-insurance, or non-covered services.
   - Co-payments are due at the time of serve.
   - If my plan requires a referral from my PCP, I must obtain it prior to my visit.
   - In the event that my health plan determines a service to be "non-payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. **Insurance Authorization for Assignment of Benefits**

I hereby authorize and direct payment of my medical or vision benefits to Bedford Vision & Eye Clinic, PLLC on my behalf, for any services furnished to me by my providers.

3. **Authorization to Release Records**

I hereby authorize Bedford Vision & Eye Clinic, PLLC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services, as well as information required for precertification, authorization or referral to other medical providers.

4. **Medicare Request for Payment**

I request payment for authorized Medicare benefits to me, or on my behalf, for any services furnished by me or Bedford Vision & Eye Clinic, PLLC. I authorize any holder of medical or other information about me, to release to Medicare and its agents any information needed to determine these benefits or benefit for related services.

_____ _____

Signature of patient or Guardian Date

_____ _____

Print Name of Patient or Guardian Relationship to Patient