SHEPARD AND QUINTON VISION CARE

Financial/Insurance Information

Payment is due at the time services are rendered. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges.

If you have medical insurance, we are eager to help you receive your maxim allowable benefits from your healthcare plan. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. Not all services are covered benefits in all contracts.

We emphasize that as healthcare providers our relationship is with you, not your insurance company. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. I agree to pay all expenses, including attorney costs, associated with the collection efforts for services and goods provided by this office.

Assignment of Benefits - I hereby assign payment directly to Denise Q. Shepard, OD, insurance benefits otherwise payable to me. I understand that I am responsible for charges not covered by this assignment.

Release of Information - I hereby authorize Denise Q. Shepard, OD to release to any insurance company or potential third party payer any information requested by any such insurance company or potential third party payer when it is anyway related to a request for a determination or verification of expense coverage or when it is related to the payment of a claim for treatment expenses or services.

These assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient: _____ Date: _____

Medicare Patients Only

Assignment of Benefits - I request payment of authorized Medicare benefits be made to Denise Q. Shepard, OD for any covered services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Waiver of Liability - I understand Medicare will not cover any services determined as routine or screening. I understand I will be financially responsible for these charges. These services include refraction, routine eye exams, glasses and contact lenses (with the exception of after cataract surgery or for aphakic patients), no-line bifocals, progressive and transition lenses, not medically necessary tints, scratch coats, other additional patient options for glasses, contact lenses cleaners and solutions. Other non-covered services by the Medicare program include low vision exams, low vision aids, and vision therapy.

Medicare/Medigap Benefits - I request that payment of authorized Medigap benefits be made to Denise Q. Shepard, OD for any covered services furnished to me. I authorize Denise Q. Shepard, OD to release any information requested by my Medigap insurance carrier when it is anyway related to a request for a determination or verification of expense coverage or when it is related to the payment of a claim for treatment expenses or services.

These assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient: _____ Date: _____