GULFSTREAM EYE
Restorative & Aesthetic Eyelid Surgery

2100 Nebraska Avenue, Suite 113
Fort Pierce, Florida 34950
Phone: 772-448-4865
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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS
INSURANCE INFORMATION, FINANCIAL AGREEMENT

Patient's Name: _____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Gulfstream Eye, for services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated as a Secondary Insurance (in Item 9 of the HCFA 1500 claim form or electronically transmitted), my signature authorizes releasing the information to the insurer shown. Gulfstream Eye, accepts the charge determination of Medicare and I am responsible for coinsurance, deductibles and non-covered services.

OTHER INSURANCE: I request that payment of authorized benefits be made on my behalf to Gulfstream Eye, for services furnished to me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

FINANCIAL AGREEMENT: I agree that in return for the services provided by Gulfstream Eye, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the practice. If my account is sent to collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. Most insurance companies require you to pay co-payments and deductibles. These are due, if known, at the time of service as well as any non-covered services. It is understood that I am primarily responsible for the payment of any services not covered by my insurance.

_____ _____
Signature of Patient or Authorized Representative Date