Medicare and Insurance Authorization

I, _____ request that payment of authorized Medicare and/or Insurance or Benefits Company be made on my behalf to Jeffrey E. Schultz, OD, Inc. for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or applicable Insurance or Benefit Company, any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made, and authorizes release of any medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the Insurer or Agency shown.

Any services recommended or provided by this office may not be covered under the terms of your benefit plan. Eligibility and coverage are subject to the specific terms and conditions of your benefit plan.

In the event that I am billed by Jeffrey E Schultz, OD, Inc., and my financial responsibility is not reimbursed in a timely manner and should the need arise, I agree to pay any collections fees, court costs and attorney's fees.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the 20% deductible Medicare does not cover and non-covered services. I understand that my secondary Insurance may cover the 20% deductible; however, my secondary Insurance may have its own deductible program. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. The doctor's office will include coinsurance information when submitting Medicare claims, but since the office may not accept the coinsurance, the patient agrees to pay the 20% Medicare or coinsurance does not cover, and if the coinsurance reimburses the office, it will be immediately reimbursed to the patient.

X_____ ____/____/____

Signature of Patient or Beneficiary Date

_____

Relationship to Patient