MILLS

EYE +
FACIAL SURGERY

David M. Mills **MD, FACS**
Ophthalmologist +
Facial Plastic Surgeon

+ Crestview
182 E. Redstone
Ste. A
Crestview, FL 32539

+ Gulf Breeze
1300 Shoreline Dr.
Ste. 104
Gulf Breeze, FL 32561

+ Pensacola
9050 University Pkwy
Pensacola, FL 32514

Authorization, Assignment of Benefits, Financial Agreement:

1. **It is the responsibility of the patient to review his/her insurance coverage and to know if a referral is necessary, precertification is required, or a second opinion in necessary.**
2. **Co-pays, Co-insurance and deductibles are** due at the time of service and are collected at check in.
3. **Payment arrangements** and billing questions can be done through our billing office at (850) 266-7500
4. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Mills Eye + Facial Surgery for services furnished me by their providers. I authorize any holder of medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits pay-able for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay any and all claims. If other health insurance in indicated in Item 9 of the CMS-1500 form or elsewhere on the approved claim forms, my signature authorizes releasing information to the insurer or agency shown. Mills Eye + Facial Surgery accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurances and deductible are based upon the charge determination of the Medicare carrier.
5. **SECONDARY/MEDIGAP:** I understand that if a Secondary/MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 claim form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Mills Eye + Facial Surgery.
6. **OTHER INSURANCE:** I understand that Mills Eye + Facial Surgery maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Mills Eye + Facial Surgery has no contract, expressed or implied, with any plan that does not appear on the list. I understand and agree that I am individually obligated to pay the full charges of all services rendered to me by Mills Eye + Facial Surgery if I belong to a plan that does not appear on the above mentioned list.
7. **NON-COVERED SERVICES**: I understand that Mills Eye + Facial Surgery's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patients' contract with a health care service plan or the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan.
8. **RELEASE OF INFORMATION**: Mills Eye + Facial Surgery may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Mills Eye + Facial Surgery for reimbursement of services rendered, and (2) any health care provider for continued patient care. A copy of this authorization may be used in place of the original.
9. **FINANCIAL AGREEMENT**: I agree that in return for the services provide to the patient by Mills Eye + Facial Surgery, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Mills Eye + Facial Surgery payment. An account with a patient balance that receives NO RE-SPONSE AFTER 60 DAYS may be sent to an attorney or collection agency for collection. I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Mills Eye + Facial Surgery. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill/account.
10. CONSENT OF TREATMENT: I hereby grant my authorization and consent for medical treatment and procedures for myself and/or minor children, and certify that

+ Ophthalmology
+ OculoFacial Plastic Surgery
+ Facial Cosmetic Surgery

no guarantee or assurance has been made as to the results which may be obtained.

Patient Name (please print): ____
DOB: _____ / _____ / ______
Signature of Patient or Guarantor: ____
Date: _____ / _____ / ______