

1. FINANCIAL RESPONSIBILITY POLICY

The following statements set forth the detailed policy of Kokopelli Eye Care with regard to financial responsibilities.

- All patients are held personally responsible for prompt and full payment of fees. A billing statement will be provided so that the patient can file a claim with their insurance carrier for reimbursement.
- Kokopelli Eye Care is under contract with Medicare and will accept assignment on all claims. Patients will be responsible for the deductible and the small balance which Medicare allows but does not pay. Kokopelli Eye Care will bill your secondary insurance company if you want them to.
- Patient accounts which become delinquent shall be assigned to our collection department for resolution. Such assignment gives the patient responsibility for the balance and additional costs incurred in the collection process including, but not limited to, interest, filing fees, attorney fees, and court costs.

IT IS UNDERSTOOD THAT THE UNDERSIGNED/PATIENT ARE RESPONSIBLE FOR PAYMENT OF PATIENT'S BILL.

Patient/Responsible Party

Date

2. MEDICARE LIFETIME AUTHORIZATION:

"I request that payment of authorized Medicare benefits be made on my behalf to Kokopelli Eye Care for any services furnished me by that physician/supplier. 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 the benefits payable for related services."

Signature of Patient

Date

3) DIRECT PAYMENT TO KOKOPELLI EYE CARE FROM HEALTH INSURANCE COMPANY:

"I request that payment of authorized insurance benefits be made on my behalf to Kokopelli Eye Care for any professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

Signature of Policy Holder

Date

Signature of Claimant:
(If other than policy holder)

Date

4) RELEASE OF INFORMATION

Kokopelli Eye Care may disclose all or any part of the patient's medical records to the following:

- A. Third Party: Including but not limited to any person or corporation, or their designee, which may be liable under a contract for payment of all or part of Kokopelli Eye Care's charges, such as insurance companies, workers' compensation payers, hospital or medical employer; quality assurance and peer review committees, utilization review organizations, Medicare review organization; accrediting surveyors; clinic and treating physician's, and professional liability insurance carriers.

- B. Medical Research: Information may be released for use in medical studies and medical research.

C. Other Health Care Providers: Information may be released to other health care providers to whom I may be referred in order to provide continued patient care.

I understand that the authorization granted above maybe revoked by me at any time. The authorization will stay in effect as long as the need for die above information exists.

Signature of Patient

Date