KOKOPELLI
EYE INSTITUTE

OUR VISION IS TO CARE ABOUT YOURS

1. **FINANCIAL RESPONSBILITY POLICY:**
   The following statements set forth the detailed policy of Kokopelli Eye Institute 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, if necessary.

   Kokopelli Eye Institute 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 Institute will bill your secondary insurance company if you want us to do so.

   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

2. **MEDICARE LIFETIME AUTHORIZATION: (If and when covered by Medicare)**
   I request that payment of authorized Medicare benefits be made on my behalf to Kokopelli Eye Institute 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.

3. **DIRECT PAYMENT TO KOKOPELLI EYE INSTIUTE FROM HEALTH INSURANCE COMPANY:**
   I request that payment of authorized insurance benefits be made on my behalf to Kokopelli Eye Institute 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.

4. **RELEASE OF INFORMATION:**
   Kokopelli Eye Institute 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 Institute'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.

********** **Lifetime Authorization** **********

I understand that the authorization granted above may be revoked by me at any time, with written notice. This authorization will stay in effect as long as the need for the above information exists. A photocopy of this assignment shall be considered as effective and valid as the original.

Signature _____ Date _____