Michigan Oculofacial Specialists

ASSIGNMENT OF INSURANCE BENEFITS

It is important that you read and sign your name at the bottom of the page.

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made on my behalf to Lawrence Handler MD for any services furnished to me by the listed providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

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 for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment is effective until evoked by me in writing.

Medi-gap (Medicare Supplemental Insurance) Assignment of Benefits

I request payment of authorized Medi-gap benefits to be made to the Provider(s) and also authorize any holder of medical information about me to release to the Medi-gap insurer any information needed to determine benefits payable for services from the Provider(s). This assignment is effective until evoked by me in writing.

General (Commercial Insurance) Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the Provider(s) for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider(s).

I understand that I am financially responsible to the Provider(s) for any charges not covered by my health benefits. It is my responsibility to notify the Provider(s) of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill if the submitted claim or any part of them are denied for payment. **It is my responsibility to understand my insurance benefits and plan coverage. I accept financial responsibility for payment for all services or products received.**

Financial Policies

Payment Policy: Your office visit copay will be due at the time of your visit. Please be prepared to make this payment at that time. For your convenience, we accept VISA, MasterCard, Discover Card, American Express, Care Credit, Checks or Cash. Please make your checks payable to Lawrence Handler MD. There will be a $40.00 charge for returned checks.

Additional Fees: If you are scheduled for surgery and/or require any leave of absence forms to be filled out, there will be a $20.00 charge for this service. There will also be a late Fee of $15.00 added to your account after the initial statement if payment in full is not received.

By signing this document, I understand and agree with the Assignment of Benefits and Financial Policies listed above.

_____ _____

Patient/Legal Representative Signature **Date**