

### DILATION EYE DROPS

Dilating drops are used to dilate or enlarge the pupil of the eye to allow the ophthalmologist to view the inside of the eye, the retina. Dilating drops cause blurred vision for 4 to 6 hours which may make bright lights bothersome. It is not possible for your ophthalmologist to know how much your vision will be affected. Because driving may be difficult, you may want to plan for a ride.

### PATIENT FINANCIAL RESPONSIBILITY

I acknowledge that I am financially responsible for all charges, balances or fees not covered if I have no coverage, my insurance is rejected, or the doctor is out of network. I understand if for any reason my insurance company does not pay my bill within (90) days, I will be financially responsible. I also understand that I am responsible for any deductible or co-payment that is due at the time services are rendered.

### RELEASE OF INFORMATION

I hereby authorize Miami Eye Specialists to release information acquired during my examination to my insurance company or employer for Workman's Compensation.

### ACKNOWLEDGEMENT

I acknowledge that the privacy practices of this office are available upon my request. I attest that I have read and understand the Patient Registration form and any questions have been answered.

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PRINT PATIENT NAME

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DATE

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PATIENT SIGNATURE

**NORTH SHORE MEDICAL OFFICE BUILDING**  
1190 NW 95TH STREET, STE 201  
MIAMI, FL 33150  
PHONE: 305-694-1872  
FAX: 305-694-1950

**MEDICAL PLAZA**  
182 NE 168TH STREET  
NORTH MIAMI BEACH, FL 33162  
PHONE: 305-651-4300  
FAX: 305-651-0701

**MEMORIAL WEST MEDICAL BUILDING**  
601 N FLAMINGO ROAD, SUITE 315  
PEMBROKE PINES, FL 33028  
PHONE: 305-651-4300

## SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

\_\_\_\_\_  
PATIENT'S NAME (PRINT)

**1. MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **Miami Eye Specialists** for services furnished me by **Miami Eye Specialists**. 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. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **Miami Eye Specialists** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

**2. MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS1500 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 **Miami Eye Specialists**, if possible or otherwise to me.

**3. RELEASE OF INFORMATION:** **Miami Eye Specialists** 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 **Miami Eye Specialists** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **Miami Eye Specialists** may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

**4. OTHER INSURANCE:** I understand that **Miami Eye Specialists** 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 **Miami Eye Specialists** has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by **Miami Eye Specialists** if I belong to a plan that does not appear on the above mentioned list.

**5. NON-COVERED SERVICES:** I understand that **Miami Eye Specialists'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, which are 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 patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with **Miami Eye Specialists** to obtain necessary health care service plan authorizations.

**6. FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by **Miami Eye Specialists**, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to **Miami Eye Specialists** for payment. If an account is sent to an attorney 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 **Miami Eye Specialists**. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Miami Eye Specialists**. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

\_\_\_\_\_  
PATIENT SIGNATURE OR AUTHORIZED PAY

\_\_\_\_\_  
DATE