LIFETIME AUTHORIZATION

Frantz EyeCare / Suncoast Surgery Center

I authorize financial information and reports of my evaluation, treatments and any follow-up evaluations to be sent to or discussed with my referring doctor, the doctor requesting consultation, my family physician, as well as any other healthcare providers, hospitals or outpatient facilities that I have or will identify with you.

I authorize the holder of my medical records or other information about me, to be released to:

- Social Security and Health Care Financing Administration or its intermediaries or carriers, and/or
- Billing agents of my insurance companies, and/or

any information needed for this insurance or Medicare claim. I permit a copy/fax of this authorization be used in place of the original. I request payment of medical insurance benefits to the party who accepts assignment.

MEDIGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made on my behalf for any services furnished to me by that physician. I authorize any holder of medical information about me to release to primary / secondary / tertiary/Medigap carriers any information needed to determine benefits or the benefits payable for related services. This authorization applies to all occasions of service until it is revoked in writing by me.

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as a part of my electronic health record, Frantz EyeCare, will transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, Frantz EyeCare will obtain the history of all of my past prescriptions dating back two years from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health record.

FINANCIAL AUTHORIZATION

I understand that it is my responsibility to provide current and correct insurance information, as well as obtain any authorizations and pre-certifications necessary. In the event that this is not done, I understand that I will be responsible for payment of all unpaid services. Overdue balances will be subject to a $10 service fee per month until the outstanding balance is satisfied. I also understand that I am fully and legally responsible for all charges for services rendered, which includes all outstanding balances not covered by Medicare and/or insurance companies; and that any unpaid balances are subject to interest that shall accrue at the maximum rate permitted by law.

CREDIT SURCHARGE NOTICE/RETURNED CHECK POLICY

We impose a 3% surcharge on credit card purchases that is not greater than our cost of acceptance. Purchases made with a debit card, prepaid card, cash or check will not be surcharged. If your check is returned, we will apply a return fee of $25 for checks under $50, $30 for checks under $300 and $40 for checks greater than $300.

We kindly request a 24-hour cancellation notice. If you fail to arrive for any appointment or provide less than 24-hours notice you may be subject to a $50 "no show" fee.

I understand that failure to pay my account or to make suitable financial arrangements to pay my account may result in my account being turned over to a collection agency. Should it become necessary to take my debt to collection, I agree to pay all collection costs which include, but are not limited to, fees, court costs, attorney fees and any other fees or cost for the collection of my account balance.

I understand that the **REFRACTION FEE IS NOT COVERED** by Medicare and/or insurance companies.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____