

Eye Physicians of Central Florida  
A Division of Florida Pediatric Associates, LLC

**Signature on File, Assignment of Benefits, Financial Agreement, Privacy Notice**

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**1. Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to **Eye Physicians of Central Florida**, for the services furnished me by **Eye Physicians of Central Florida**. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (formerly Health Care Financing Administration) 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 HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **Eye Physicians of Central Florida** 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.

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**2. Medigap:** I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 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 **Eye Physicians of Central Florida**, if possible or otherwise to me.

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**3. Release of Information:** **Eye Physicians of Central Florida** 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 **Eye Physicians of Central Florida** for reimbursement for services rendered, and (2) any health care provider for continued patient care. **Eye Physicians of Central Florida** 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

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**4. Other Insurance:** I understand that **Eye Physicians of Central Florida** maintains a separate contract with each participating insurance plan. The most up-to-date list is available from the business office. I understand that this list is not all-inclusive and it is my responsibility to verify individual participation with my insurance plan as not all physicians of **Eye Physicians of Central Florida** participate with the same insurance plans. The undersigned agrees to be individually obligated to pay the full charges of all services rendered by **Eye Physicians of Central Florida** if I belong to a plan in which the physician of **Eye Physicians of Central Florida** is not participating.

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**5. Non-Covered Services:** I understand that **Eye Physicians of Central Florida'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 **Eye Physicians of Central Florida** to obtain necessary health care service plan authorizations.

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**6. Financial Agreement:** I agree that in return for the services provided to the patient by **Eye Physicians of Central Florida**, I will pay my account at the time service is rendered or provide proof of current insurance coverage. **Eye Physicians of Central Florida** will file my insurance as a courtesy. I understand that if my account is not paid by my insurance in full within 60 days of the date of service, I am responsible for payment in full. 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. Benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to **Eye Physicians of Central Florida**. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Eye Physicians of Central Florida**. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

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**7. Missed Appointments:** **Eye Physicians of Central Florida** requires 24 hour advance notice for all missed, cancelled or rescheduled appointments. Failure to notify our office will result in a **\$30 fee**. Emergencies will be considered on a case by case basis for waiver of this fee.

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**8. Notice of Privacy Practices:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you in the process of providing treatment, seeking payment or carrying out our own health care operations. This notice contains a Patient Rights section describing your rights under the law. A copy of the current notice in effect will be posted. Each time you receive treatment or healthcare services you may request a copy of the current notice.

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Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

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Patient Signature

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Parent or Guardian Signature (if minor)

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Print Name