TALLEY MEDICAL-SURGICAL EYE CARE ASSOCIATES
6149 E. Columbia St • EVANSVILLE IN 47715
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RESPONSIBILITY, CONSENT & ASSIGNMENT OF BENEFITS

MEDICAL CONSENT. I, the undersigned, being the person whose name appears hereafter designated as "patient" or being a person legally authorized to consent to services on behalf of the patient, do hereby consent and authorize the doctors of Talley Medical-Surgical Eye Care Associates, PC ("Doctor Office") to: (1) discuss, document and securely store my health history/information and (2) provide an in-office or bedside examination of my eyes and/or body as deemed necessary by my doctor in order to appropriately arrive at a diagnosis and treatment plan. I understand that some preliminary information gathering and basic testing done in the office is often performed by members of my doctor's staff as well as by the doctor him(her)self and this routine work-up often includes the instillation of eye drops for various reasons- such as to check eye pressure and to dilate the pupils. Because of this, this consent and authorization also extends to and includes: staff doctors, interns/students, nurses/nurse's aides, technicians and agents and employees of the Doctor Office providing services to the patient. I understand that the patient is under the care of the attending doctor and that such doctor is responsible for determining the nature and course of treatment for the patient. The attending doctor will recommend treatment for the patient and the patient will have to decide whether to follow those recommendations or not. The consent given here **does NOT** extend to initiation of any oral or IV medications nor any surgical procedures or injections performed whether in the Office or a surgical facility. Separate consent must be obtained for any of these procedures.

RELEASE OF INFORMATION. The undersigned agrees that to the extent necessary to determine responsibility for payment and to obtain reimbursement, the Doctor Office may disclose portions of the patient's record, including their medical records, to any person or entity which is or may be responsible for all or any portion of the Doctor's Office charges, including but not limited to insurance companies, health care service plans, worker's compensation carriers, medical or utilization review organization designated by any of the foregoing, or to any other person or entity as necessary in connection with such payment or reimbursement. I authorize any holder of medical or other information about me to release same and copies of any medical records to Doctor's Office, the Health Care Financing Administration, its agents or carriers, and my insurance carrier(s), necessary to determine benefits and/or to process claims for this and all related claims on my behalf, now or in the future. I request my insurance company(ies) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my doctor on my behalf.

HIPAA NOTICE. I have been given the opportunity to review a Notice of Privacy Practice disclosing how my patient health information may be used and disclosed, and how I can get access to my individually identifiable health information.

DISPOSITION OF TISSUE, ETC. I authorize the Doctor Office to retain, preserve, and use for scientific purposes or disposal at the convenience of the Doctor Office, any specimens or tissues taken during my treatment.

MEDICARE CERTIFICATION. I certify that the information given by me for payment under Title XVIII of the Social Security Act is correct. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). I authorize my doctor who treats me, to release information from my medical records to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the processing of claims for medical benefits. I permit a copy of this authorization to be used in place of the original, and I request that payment of authorized benefits be made directly to my doctor treating me, on my behalf.

PAYMENT GUARANTEE. In consideration of the services delivered by the Doctor's Office and/or doctor, the undersigned guarantees payment of the account, and agrees to pay the same at the time of visit if such account is not paid by a private or governmental insurance carrier, and to pay any balance due promptly upon receipt of my first statement. I agree to comply with the terms of my insurance coverage, including payment of co-pays at the time services are rendered. I understand that all accounts are the full responsibility of the patient and/or the patient's responsible party. I understand that the Doctor's Office may add a finance charge to any outstanding balance. If the amounts due to the Doctor's Office for services rendered become delinquent and do not have agreed upon financial arrangements with the Doctor's Office, these accounts may be submitted to a collection agency or attorney for collection. I agree that I will pay all attorney fees and court costs incurred by the Doctor Office in the collection of all sums due. If I provide the Doctor Office or its agents with my cell phone number, I authorize the Doctor Office or its agents to call our cell phone either manually or by auto-dialer in order to collect any amounts that I owe. I understand that any email that I provide is my personal email and I authorize the Doctor Office to contact us via that email address.

MEDICAID. If this service is to be covered under a Medicaid Program, I understand that I must show my current Medicaid card prior to seeing the doctor, and to pay any spend down that has not been met at time of service. I agree and understand that if I am a QMB recipient, that Medicaid will extend coverage to payment of Medicare co-insurance and/or deductible only, and that I am responsible for services and supplies not covered or denied by Medicare. I further agree and understand that I am being informed, prior to receipt of service, that I may be responsible for services that the Indiana Medicaid Program determines not to be a covered benefit. I agree and understand that if I do not have my current Medicaid card that payment in full is required for this visit at the time services are rendered.

ASSIGNMENT OF BENEFITS. In consideration of services rendered to be rendered from time to time by Doctor, I hereby authorize, request, and assign payment directly to the Doctor's Office and/or Doctor covering this period of treatment and future treatment, by all insurance carriers with whom I have coverage or from whom benefits are, or may become, payable to me, including settlements or judgments flowing from the incident for which I am receiving treatment. This assignment is a relinquishment and assignment of all legal or equitable interest which I have in any insurance benefits which exist by reason or contract or otherwise, including but not limited to, Major Medical and other special coverages, and including the right to sue or make claim for said benefits; this assignment is irrevocable except upon full payment of all indebtedness, or by express written agreement between the Doctor Office, and the undersigned; this assignment does not constitute payment for indebtedness and does not relieve the undersigned from liability for unpaid indebtedness. In the event that insurance benefits to which I am entitles are paid directly to me for indebtedness incurred by me or a member of my family, or a person for whom I am financially responsible, I agree that I will immediately deliver all such benefit received.

PRIOR AUTHORIZATION. I understand that some insurance companies require prior authorization for certain procedures, and that maximum reimbursement and coverage may not be received if prior authorization is not obtained. I assume the responsibility of obtaining such authorization if necessary. NOTICE: Your health insurance plan may require you to obtain some medical services from certain providers in order to be fully covered for those services under your plan. Please be sure to review your health care insurance plan before receiving any services at the Doctor's Office. In most cases, your insurance card will list a telephone number that you may call to obtain your health insurance benefit coverage's and any restrictions on choosing a provider. Talley Medical-Surgical Eye Care Associates offers a full range of the services you may need; however, in order to receive maximum insurance payment, you need to know your health insurance benefits coverage and which providers the insurance will fully pay.

THE UNDERSIGNED CERTIFIES THAT THEY HAVE READ AND UNDERSTAND THE FOREGOING AND EITHER IS THE PATIENT NAMED OR IS DULY AUTHORIZED BY THE PATIENT OR BY LAW TO ACCEPT THE TERMS ON THE PATIENT'S BEHALF.

_____	_____	_____
Signature of Patient / Legal Representative	Date	Relationship of Legal Representative

_____	_____	_____	_____
Signature of Guarantor (if other than above)	Date	Signature of Witness	Date

_____	_____
Policyholder (if other than Guarantor)	Date