Please review and *Sign all that apply*. Your signature attests that you understand and accept the policy stated below:

Patient name: _____ Date of Birth: _____

In order to control the cost of billing, we ask that the patient's portion of their bill is paid at the time services are rendered unless other arrangements have been made in advance. There will be a $25.00 service charge on all returned checks. ***We are required by your insurance company to collect your Copayment at the time of service.*** Refraction fees must also be collected at the time of service. If you are unable to pay your Copayment or Refraction fee today, there will be an additional *$10.00 fee*. **I understand that it is my responsibility to understand my insurance coverage (medical and/or vision) and obtain a referral if necessary for payment. If you have questions about your coverage please contact you employer or your insurance company.** The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. I understand accounts 90 days or older are subject to 33 1/3% collection fees, court costs and attorney fees, which I agree to pay. I am aware that Antietam Eye Associates has patient and optical policies and understand that they are available to me at any time upon request.

Signature **Date**

I request that payment of authorized Medicare benefits be made on my behalf to Antietam Eye Associates for dates of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related service.

Signature **Date**

Payment from my insurance is to be paid directly to *Antietam Eye Associates*. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when a claim is processed. I authorize *Antietam Eye Associates* to release any information, including diagnosis and the records of any treatment or examination to **third party payers** and/ or **health practitioners**.

Signature **Date**

Often my eye doctor will find it necessary to dilate my pupils during my exam. Dilating drops frequently blur vision for some length of time and may make bright lights bothersome. I understand that due to this, driving may be difficult and have made appropriate arrangements. I hereby authorize my doctor and/or his /her assistant to administer dilating eye drops, since dilation may be necessary to diagnose my ocular medical issues.

Signature **Date**