LIFETIME AUTHORIZATION OF INSURANCE BENEFITS

By signing below, I request that payment of insurance benefits be made on my behalf to Vision Source of Amherst and Greenfield for any services furnished me by their physicians/suppliers. I understand that my signature requests that payment be made and authorizes the release of any medical information necessary to ensure payment. I understand that it is my responsibility to provide Vision Source of Amherst and Greenfield with the necessary insurance information so that claims may be submitted according to my carrier's requirements.

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made on my behalf to Vision Source of Amherst and Greenfield for any services furnished me. I authorize holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I further understand that Vision Source of Amherst and Greenfield has agreed to accept the allowed charge determined by Medicare as the full charge. Medicare pays 80% of that charge, and I understand that I am responsible for the balance of the charge, deductibles, co-insurance and non-covered services. Co-Insurance and deductibles are determined by the carrier. **I understand that Medicare excludes all refractive services (checking my glasses prescription) from their coverage**. **I agree to be personally and fully responsible for the refractive portion of my exam.** Medicare (and most other insurances) does not cover eyeglasses or medications in most cases. If other health insurance coverage is indicated (secondary insurance), my signature authorizes payment of benefits to Vision Source of Amherst and Greenfield and release of medical information necessary to process that claim to that insurer or agency.

HMO/PRIOR AUTHORIZATION PATIENTS: I understand that I am ultimately responsible for authorizations for care/treatment to be provided by Vision Source of Amherst and Greenfield. If for ANY reason a service is not authorized or is denied, I assume full responsibility for any and all charges, including co-payments and deductibles.

PRIVATE PAY PATIENTS: Payment for services rendered is expected at the time of service.

I have read the above information. I understand that all charges for services rendered are ultimately my responsibility. Should Vision Source of Amherst and Greenfield not be a contracted provider, or if the services rendered are not a covered benefit under my plan, I am responsible for all charges related to the services provided me and will pay in full for such charges.

_____ _____

PATIENT (RESPONSIBLE PARTY) SIGNATURE DATE

_____

Print name of patient

A copy of this form will be provided to you at your request.