SIGNATURE ON FILE

Beneficiary's Name (Please Print) _____ Medicare Identification Number _____

MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to *Drs. McKinney & Simmonds, Optometrists, LLC* for services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to 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.

Drs. McKinney & Simmonds, Optometrists, LLC accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature _____ Date _____

MEDIGAP

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 either to me or on my behalf to *Drs. McKinney & Simmonds, Optometrists, LLC.*

Signature _____ Date _____

OTHER INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to *Drs. McKinney & Simmonds, Optometrists, LLC.* I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to *Drs. McKinney & Simmonds Optometrists, LLC.* I authorize *Drs. McKinney & Simmonds, Optometrists, LLC* to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Signature _____ Date _____