AUTHORIZATION & RESPONSIBILITY AGREEMENT

We invite you to discuss with us any questions regarding our services or policies. The best health services are based on a friendly, mutual understanding between provider and patient.

YOUR insurance policy is a contract between you & your insurance company. We are NOT a party to that contract! Our relationship is with you NOT your insurance company! While we accept many of the major insurance's it is your responsibility to verify Somerset Ophthalmology PC participates with your individual plan. **While our staff may be able to answer some basic questions this no ways implies your services will be covered.** This information can and only should come from your employer and or your insurance representative. They are your best source of reference as to what you can expect from your plan/policy.

The policy at Somerset Ophthalmology PC with regards to your insurance is as follows you, the patient,/insured will release ANY and ALL pertinent information relating to your insurance coverage/policy. Somerset Ophthalmology PC MUST have on file ALL demographics needed to successfully submit a claim on your behalf. We will maintain a copy of your current insurance card/cards, driver's license & current demographics. At times we may need your social security number in accordance with your medical insurance coverage. Under HIPPA guidelines all current & necessary steps with regards to securing your private information are in place. Somerset Ophthalmology PC has successfully passed all requirements needed to act on your behalf and send information relating to you as a patient, services rendered through electronic means. REMEMBER it is your responsibility as an insured/patient to keep your information up to date this will avoid unnecessary delays/rejections. If the information in the patients profile is incorrect it will result in the unpaid balance to the patient/insured.

I hereby authorize my insurance company to pay directly to Somerset Ophthalmology PC any professional or medical expense benefits for services rendered. If my insurance company DOES NOT PAY my balance in full within 30 days, I will be responsible for contacting my carrier to inquire about the delay. I also authorize Somerset Ophthalmology PC to release any information pertinent to my case to any insurance company, adjustor, & attorney involved in this case; and hereby release Somerset Ophthalmology PC from any consequence thereof. A photocopy of this assignment shall be considered as effective & valid as the original.

I understand it is my responsibility to inform this office of any changes in my medical insurance status.

______________________________________ ____________

Patient/Responsible Person signature Date

FINANCIAL RESPONSIBILITY

Our office policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the office manager. The insured/patient will pay all co pays & deductible associated with their insurance policy/coverage at the time of service should we accept & bill their current insurance carrier. Many health insurance plans DO NOT COVER REFRACTIONS the portion of your complete ophthalmalic exam which determines your need for an eyeglass prescription. In the event of default I further understand that I(insured/patient) am responsible for any & all attorney's fees, costs & delinquency fees associated with my account. Returned checks will be accessed the current fee.

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Signature of patient or responsible person Date