PAVELOFF VISION CENTER
MICHAEL J. PAVELOFF, M.D., INC, F.A.C.S.
1532 ANACAPA STREET, SUITE 5
SECOND FLOOR
SANTA BARBARA CA, 93101
(805) 682-4459 FAX (805) 682-5355

Signature on File, Assignment of Benefits, Financial Agreement

Insured Name (*print*) _____ Medicare/Insurance Policy Number _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to the Paveloff Vision Center, for services furnished to me by Dr. Michael J. Paveloff. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to the insurer or agency shown. I understand I am responsible for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare of the Medicare Carrier.

2. **MEDIGAP (SECONDARY INSURANCE):** I understand that 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 on my behalf to Dr. Michael J. Paveloff if possible or otherwise me.

3. **RELEASE OF INFORMATION:** Paveloff Vision Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Dr. Michael J. Paveloff for reimbursement for services rendered, and (2) any health care provider for continued patient care. Paveloff Vision Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal Law, statute or regulation. A copy of this authorization may be used in place of the original. In addition, I authorize release of my medical information to _____.

4. **OTHER INSURANCE:** The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Dr. Michael J. Paveloff if I belong to a plan that does not contract with Paveloff Vision Center. I understand that I am responsible for deductibles, co-payments and services not covered by my insurance. I understand my signature requests that payment be made and authorizes release of the information necessary to the insurer or agency shown.

5. **NON-COVERED SERVICES:** I understand that Paveloff Vision Center contracts with health care service plans (i.e., PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Paveloff Vision Center to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Dr. Michael J. Paveloff, I will pay my account at the time service is rendered or will make financial arrangements satisfactory Paveloff Vision Center for payment. If an account is sent to an attorney or collection agency for collection, I agree to pay collection expenses and reasonable attorney's fees as estimated by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Paveloff Vision Center. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

_____ _____

Insured Signature or Authorized Party Date