INSURANCE

Patient's Name_____ Date of Birth_____

MEDICARE

1. Medicare Number _____
2. Has yearly deductible for Medicare been met? YES_____ NO_____
3. Medicare regulations suggest that we inform you in advance if we believe a service or material not be covered or fully reimbursed by Medicare. In our professional judgment the following services may be needed in order to give you high-quality care, but may not be reimbursed by Medicare. If these items are needed and billed you will be fully responsible.

Refraction Fee (check-up for glasses)

_____ _____ _____

_____ _____ _____

MEDICARE CO-INSURANCE

Subscriber's Name _____ Insurance Company Name _____
ID# _____Group# _____
Street_____City_____State_____Zip_____

PATIENT AGREEMENT AND SIGNATURE ON FILE

"I certify that I have read and fully understand the above information. I have advised the Doctor and staff to proceed with the services today whether or not they are covered by Medicare or my insurance. I request that payment of authorized benefits be made to Fairmont Eye Care, Inc. For services furnished to me and billed to Medicare. I certify that information given by me is correct. I understand that **I am responsible** for payment in full if Medicare or my insurance denies payment for covered or non-covered services."

___Patient Signature_____Date_____

DELUXE FRAME

An extra charge for deluxe frames is not covered by Medicare. Standard frames are available and are covered by Medicare; unmet deductibles and your 20% co-pay still apply, however. Frames and lenses are covered only after cataract surgery and for just one pair. The extra charge for the deluxe frame is _____.

___Patient Signature_____ Date_____

PRIMARY INSURANCE AND SIGNATURE ON FILE

Subscriber's Name _____Insurance Company Name _____
ID# _____Group# _____
Street_____City_____State_____Zip_____

" I have advised the Doctor and staff to proceed with the services today whether or not they are covered by my insurance. Benefit payments may be made directly to Fairmont Eye Care, Inc. If so requested by the Doctor or staff. I authorize release of any medical or other information about me needed to determine my eligibility for benefits. I certify that information given by me is correct. I understand that I am responsible for payment in full if my insurance denies payment for covered or non-covered services. In addition if Fairmont Eye Care, Inc. elects to receive payment directly from my insurance company and full payment is not received within 60 days I understand I am responsible for payment in full."

Patient's Signature _____Date_____