LIFETIME AUTHORIZATION

Frantz EyeCare

Suncoast Surgery Center

I authorize financial information and reports of my evaluation, treatments and any follow-up evaluations to be sent to or discussed with my referring doctor, the doctor requesting consultation, my family physician, as well as any other healthcare providers, hospitals or outpatient facilities that I have or will identify with you.

I authorize the holder of my medical records or other information about me, to be released to:

Social Security and Health Care Financing Administration or its intermediaries or carriers, and/or
Billing agents of my insurance companies, and/or
My employer if this is a worker's compensation claim

any information needed for this insurance or Medicare claim. I permit a copy/fax of this authorization be used in place of the original. I request payment of medical insurance benefits to the party who accepts assignment.

Patient Signature:_____ Date:_____

Parent/Legal Guardian_____ Date:_____

Medigap Authorization

I request that payment of authorized Medigap benefits be made on my behalf for any services furnished to me by that physician. I authorize any holder of medical information about me to release to primary / secondary / tertiary/Medigap carriers any information needed to determine benefits or the benefits payable for related services. This authorization applies to all occasions of service until it is revoked in writing by me.

Beneficiary Name:_____ Account #:_____

Beneficiary Signature:_____ Date:_____

Financial Authorization:

I understand that it is my responsibility to provide current and correct insurance information, as well as obtain any authorizations and pre-certifications necessary. In the event that this is not done, I understand that I will be responsible for payment of all unpaid services. I also understand that I am fully and legally responsible for all charges for services rendered, which includes all outstanding balances not covered by Medicare and/or insurance companies; and that any unpaid balances are subject to interest that shall accrue at the maximum rate permitted by law.

I understand that the refraction fee is not covered by Medicare and/or insurance companies.

I understand that failure to pay my account or to make suitable financial arrangements to pay my account may result in my account being turned over to a collection agency. Should it become necessary to take my debt to collection, I agree to pay all collection costs which include, but are not limited to, fees, court costs, attorney fees and any other fees or cost for the collection of my account balance.

Patient Signature:_____ Date:_____

Guarantor Signature:_____ Date:_____