INSURANCE POLICY

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed insurance company and assign directly to Dr. Cavett (D.B.A. Cavett Eye Care) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

FOR MEDICARE PATIENTS ONLY

Medicare patients are responsible for their deductible and the 20% copayment that Medicare does not pay. If you have met any portion of your deductible or have a supplement, a portion of this charge may be reduced. You may also be responsible for a $45 refraction fee that is usually never covered by Medicare or any other major medical insurance. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Cavett for any services furnished me by Dr. Cavett. 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 or the benefits payable for related services. I understand my signature requests that payment be made 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 the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or suppliers agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.