Conditions of Treatment

1. INSURANCE VERIFICATION/PRECERTIFICAION: many insurance companies require preauthorization or a second opinion for some medical procedures. It is your responsibility to determine coverage, pre-authorization or second requirements of your insurance company when you need a medical procedure. Failure to do so may result in a reduction or rejection of benefits by the insurance company. Please direct questions to your representative.

2. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my insurance company to pay Siskiyou Medical & Surgical Eye Center directly. I understand that I am responsible for charges not covered by my insurance company including late penalty charges. I agree that a photo copy of this authorization is as effective and valid as the original.

3. MEDICARE AUTHORIZATION: PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: The undersigned certifies that the information given under Title XVII of the Social Security Act is correct. The undersigned authorizes any holder of medical or other information about the patient to be released to the Social Security Administration or its intermediaries or carriers. **Medicare does not pay for refractions, and does not pay for eye exams that have a non-medical diagnosis. I understand that if Medicare denies payment for the above reason, I agree to be personally and fully responsible for payment.**

4. AUTHORIZATION FOR DISCLOSURE OF INFORMATION FOR THE PURPOSE OF SERVICE REIMBERSMENT: I hereby authorize Siskiyou Medical and Surgical Eye Center to disclose all or part of my medical record to any company that may be responsible for payment of all or part of my medical charges. Disclosure of my medical record may be necessary to determine my eligibility for benefits and to obtain reimbursement for health care services. I hereby release Siskiyou Medical and Surgical Eye Center from all legal responsibility or liability that may arise from the disclosure of my records.
I understand that I may revoke this authorization at any time in writing, except to the extent that Siskiyou Medical and Surgical Eye Center has already taken action on my claim.

5. FINANCIAL AGREEMENT: I understand that in consideration of the services rendered, I am obligated to pay Siskiyou Medical and Surgical Eye Center in accordance with regular rates and terms. I understand that I am responsible for any charges not covered by insurance and that the obligation to pay for medical services may not be deferred for any reason.

   If the account is referred to any agency for collection, I agree to pay all collection expenses.

   I HAVE READ AND UNDERSTAND THIS PATIENT FINANCIAL AGREEMENT. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND TO RECIEVE A COPY AND I ACCEPT THE RESPONIBILITY OF ITS TERMS.

_____	_____	_____
Patient/Authorized Signature	Date	Relationship to the Patient