Vision Source
Saxonburg Family Eye Care, LLC
324 Main Street, P. O. Box 500
Saxonburg, PA 16056

SIGNATURE ON FILE

_____I request that payment of authorized insurance benefits be made on my behalf to Saxonburg Family Eye Care for services furnished me by Dr. Amy Peterson, Dr. Jeffrey Peterson, Dr. Kelsey Jancaro and/or Saxonburg Family Eye Care. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim.

MEDICARE SIGNATURE ON FILE

_____I request that payment of authorized Medicare benefits be made on my behalf to Saxonburg Family Eye Care for services furnished me by Dr. Amy Peterson, Dr. Jeffrey Peterson, Dr. Kelsey Jancaro and/or Saxonburg Family Eye Care. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services 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 and authorized release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Saxonburg Family Eye Care accepts the charge determination of the Medicare carrier as the full charge, and I'm responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare Carrier.

_____ I understand that there are certain procedures that are considered to be covered by my insurance but are subject to deductibles and co-payments. I also understand that there are other procedures that have been recommended by my doctor that are considered to be non-covered by my insurance. I have been educated on the specific non-covered procedures and understand that I am responsible for payment.

ACKNOWLEDGEMENT OF RECEIPT

_____I acknowledge that I received or have been offered a copy of Saxonburg Family Eye Care's Notice of Privacy Practices.

There may be times when it is necessary for an individual directly involved in your care to call the office to inquire about your personal health or billing information. Please take a few moments to complete this section. Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

I authorize Saxonburg Family Eye Care, LLC to release/disclose my health care information to the following person(s):

_____ Relationship _____
_____ Relationship _____
_____ Relationship _____

Patient Name _____

Signature _____ Date _____

Authorized Agent _____ Relationship _____