

JOSEPH L. BACOTTI, M.D., P.C.  
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FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

Consent to treat & Agreement of Responsibility

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment. I understand that professional services will be rendered on my behalf and that I am ultimately responsible for charges incurred for these services. Payment for annual deductibles, co-payments and co-insurance are payable and will be collected at time of service. I understand that I am financially responsible for charges not covered by my insurance company. Refraction (the determination of a prescription for glasses) is not a covered service under Medicare and many other insurance companies. I agree to pay the usual and customary charges to determine my prescription for new glasses if I choose to have this test performed.

Release Of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of original. I authorize the provider, or provider's designee, to act as my agent and to do all things necessary or appropriate in helping me obtain payment from my insurance companies. I understand the provider does not accept the responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all right and claim for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

I understand the Ophthalmic Consultants of Long Island ("OCLI") has been engaged to provide certain billing and collection services to provide and hereby authorize OCLI, for the period for which it is retained, and its agents, employees, and affiliates to have access to my complete medical record for the purpose of providing such services.

Medicare & Medigap Authorization

I request payment of authorized Medicare, or Medigap, benefits be made on my behalf to Joseph Bacotti, M.D., P.C., for any services furnished to me by that physician/supplier. I authorize the holder of medical information, about me, to release to Medicare, or to such Medigap payor, and its agents any information needed to determine these benefits or these benefits payable related to services.

I understand that my signature requests that payment be made and authorize 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 other approved claim forms or electronically submitted claims; my signature authorize the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the change determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the undercover services, Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap, or a Medicare Supplemental policy, is a health policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs and Medicare does not pay. By law, this excludes a policy or plan offered by an employer to former employees, as well as a policy or plan offered by a labor organization to members or former members.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

This agreement is in effect until revoked in writing by the Patient