ONE-TIME MEDICARE AUTHORIZATION STATEMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Lance S. Ferguson, M.D. P.S.C. and Commonwealth Eye Surgery Center, which accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provide penalties for witholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Patient's (or authorized person's) signature____ Date____________

MEDIGAP AUTHORIZATION STATEMENT

I authorize any holder of medical or other information about me to release any information needed for this or a related Medigap claim and future claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Lance S. Ferguson, M.D. P.S.C. and Commonwealth Eye Surgery Center, which accepts assignment.

Patient's (or authorized person's) signature____ Date____________

OTHER INSURANCE AND MANAGED CARE AUTHORIZATION STATEMENT

I authorize any holder of medical or other information about me to release any information needed for this or a related claim and for future claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Lance S. Ferguson, M.D. P.S.C. and Commonwealth Eye Surgery Center, which accepts assignment. (I understand that I am financially responsible for all services performed at Commonwealth Eye Surgery for which I did not provide a current referral form.)

Patient's (or authorized person's) signature____ Date____________

LASER VISION CORRECTION CONSULTATION AGREEMENT

I understand that this office visit is for a free LASIK consultation and that no continued or subscriptive care (i.e., glasses, contacts or medications) will be given as a result of this visit. Any incidental medical findings that may require further medical treatment will need to be treated as a separate medical evaluation subject of the usual and customary charges associated with a medical evaluation.

Patient's (or authorized person's) signature____ Date____________

CONCERNING BILLING & INSURANCE

1) Patients who are not covered by health care insurance should remember that we expect payment in full (or appropriate payment arrangements) for all services at the time of each visit. You may pay by cash, personal check, VISA, MasterCard, Discover, American Express, Optima, or MedCash.

2) We accept reimbursement from **Medicaid** as payment in full for our services which are covered by Medicaid.

3) We participate (that is, we accept assignment for all covered services) with **TRICARE** (formerly CHAMPUS) and **CHAMPVA**; we will file your claim and then send you a statement for your cost-share, any unmet deductible, and any non-covered services after claim processing is complete.

4) We are participating providers (that is, we accept assignment for all covered services) with **Medicare Part B** (medical insurance); we will file your Medicare claim (and any **Medicare supplement -"Medigap"**-claim) and then send you a statement for your 20% co-insurance, any unmet deductible, and any non-covered services after claim processing is complete.

5) We are also participating providers for most insurance plans. **Please check with your insurance to confirm.**

6) ***It is always your responsibility to ensure that you have a current and valid referral form (or authorization) from your primary care physician if your insurance plan requires a referral form (or authorization) for medical and/or surgical speciality care.***