ATLANTIC EYE

279 THIRD AVENUE, SUITE 204. LONG BRANCH, NJ, 07740 | 732.222.7373
1963 NJ-34 BUILDING B, SUITE 101. WALL TOWNSHIP, NJ 07719 | 732.223.6555
100 COMMONS WAY # 230, HOLMDEL, NJ 07733 | 732.796.7140
180 WHITE ROAD, SUITE 202. LITTLE SILVER, NJ 07739 | 732.219.9220

PAYMENT OF PROFESSIONAL FEES

Full payment / Co-payments are due at the time of service.

We are a participating facility and accept assignment of *Medicare* benefits. You are STILL RESPONSIBLE for the Medicare deductible, 20% co-payment and Refraction fee. Medicare lifetime signature on file: "I request that payment of authorized Medicare benefits be made on my behalf to Atlantic Eye Physicians for any services furnished me by the physicians or supplier."

If your insurance company requires a referral prior to service, we cannot provide the service until YOU have secured the referral from your Primary Care Physician. "I have read and understand this document and authorize payment of any insurance benefits for unpaid services to the Atlantic Eye Physicians and understand that I am responsible for any balances or unpaid insurance claims. I authorize the release by Atlantic Eye Physicians of my medical information that is necessary to evaluate and pay my medical insurance claims."

NOTICE OF PRIVACY POLICIES

The following policy describes how your medical information may be used and disclosed by the Atlantic Eye Physicians, PA and/or the Atlantic Surgery Center. Please review it carefully. The privacy of your health information is important to us. This notice is being supplied as a part of our requirements of the health insurance portability and accountability act **(HIPAA)** that became effective on April 14, 2003.

Please list the full names of the people you authorize to have access of your medical information:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Do you authorize Atlantic Eye Physicians to leave messages containing your medical information for you on your home and/or cell phone? YES NO

By signing below, I acknowledge that I have read and understand all of the above information.

Patient Name:______________________ Date ______________________

Representative ______________________ Relation to Patient ______________________