Medicare Holders Only

SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to AccuVision EyeCare or Foresight Optometry for any services furnished to me by Drs. Michelsen or their associates.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its Agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorized the 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, my signature authorizes releasing of the information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Sign Name *(Patient, Parent/Guardian if patient is a minor)* Date

_____ _____

Print Name Relationship

Advance Beneficiary Notice of Noncoverage (ABN)

- Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.

- When you receive a service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these services, knowing that you will have to pay for them yourself.

  Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: $_____)

Medicare will not pay for:
Refraction (Check for glasses)
Eyeglasses or contact lenses
(Unless after cataract surgery, however, we are not contracted for this service)

Other:_____

_____ _____

Sign Name *(Patient, Parent/Guardian if patient is a minor)* Date

_____ _____

Print Name Relationship