

Signature on File, Assignment of Benefits, Financial Agreement

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Patient Name	Date

I request that payment of authorized Medicare benefits be made to John D. Miles, O.D. or Miles Optometric for services furnished me by that physician/supplier. 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 payable to related services.

I request that payment of authorized Medigap benefits be made to John D. Miles, O.D. or Miles Optometric for services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the insurer of agency and its agents any information needed to determine these benefits payable to related services,

I understand that John D. Miles, O.D. or Miles Optometric maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that John D. Miles, O.D. or Miles Optometric has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by John D. Miles, O.D. or Miles Optometric if I belong to a plan that does not appear on the above mentioned list.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicaid, Private Insurance, and other Health Plans to: John D. Miles, O.D. or Miles Optometric. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not to be paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I understand that I am financially responsible for all charges whether or not be paid by said insurance. I understand that any unpaid balance over 30 days old will be charged a finance charge of 21% per annum or billing fee of \$2.00 on any co-payment not paid on the date of service. I hereby agree that if this account is turned over to a collection agency and/or attorney for collection, I agree to pay reasonable attorney fees, court costs, and interest at the rate of 21% per annum on any unpaid balance.

X _____
Patient Signature Date