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INSURANCE RELEASE

I agree that I am responsible for payment for all services provided to me by Ophthalmology Consultants of Fort Wayne, P.C. ("OCFW"), subject to limitations set forth in any applicable insurance or other third-party benefits contract. I agree that I will pay all applicable insurance co-payments and deductibles. I further agree that I will pay all other outstanding balances for which I am responsible. For example, I will be responsible for any services: which Medicare, Medicaid, Medigap, or my insurance or other third-party benefits plan determines are not covered; for which the benefits have been exhausted; for which I fail to obtain any required authorization from my primary care physician; and, for which any spend down amount has not been met. I will also be responsible for any out-of-network fees and for any other amounts which are due and are not required to be written off by the contract OCFW has with my insurance or other third-party benefits carrier. I agree to pay such amounts within thirty (30) days of being notified by OCFW of the balance due. I understand that if I fail to pay my balance, my account may be turned over to a collection agency. In such an event, I agree that I will be responsible for all collection fees (including reasonable legal fees).

In the event I am eligible to receive benefits from Medicare, Medigap, Medicaid and/or any other insurance carrier for healthcare services provided to me by OCFW, I hereby assign to OCFW all rights I have to be reimbursed for medical expenses generated by OCFW with respect to Medicare, Medigap, Medicaid and/or any other insurance carrier, including any plan or policy of insurance (group or individual), flexible spending account, health savings account, health reimbursement arrangement or similar plan or reimbursement mechanism. This assignment includes all rights that I may have under the Employee Retirement Income Security Act of 1974, including, but not limited to, all rights concerning obtaining copies of plan/ policy documents, rights to reasonable and customary fee schedules, and rights to appeal any full or partial claim denial for treatment by OCFW. In addition, I hereby request that payment of any authorized Medicare benefits, Medigap benefits, Medicaid benefits and/or insurance or other third-party benefits be made directly to OCFW. If said benefits are not paid directly to OCFW, I agree to forward to OCFW all payments that I receive immediately upon my receipt. To assist this process, I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, Indiana Health Coverage Programs/Medicaid and/or any other insurance or third-party payor and their respective agents any information needed to determine the benefits payable for the services rendered to me. Further, to the extent I have a worker's compensation claim, I authorize OCFW to release medical information regarding services provided by OCFW as a result of the worker's compensation injury that occurred on the ___day of _________________, 20____, to my employer upon my employer's request.

I certify that I understand and agree to comply with the financial responsibilities and assignment of benefits set forth above.

Printed Name of Patient or Responsible Party ____ Date___________________________

Signature of Patient or Responsible Party ____