MOLLICK PROFESSIONAL CENTER
EYE EXAMINATIONS AND CONSULTATIONS

PERRY S. MOLLICK, M.D., F.A.A.O.
ANDREW P. GREENBERG, M.D.

SIGNATURE ON FILE (MEDICARE PATIENTS ONLY)

******As you know Medicare pays 80% of their allowed amount. The other 20% will be submitted to your secondary insurance. If you do not have a secondary plan, you will be required to pay the 20% at the time of service. Please try to keep this in mind for future visits.**

Please be advised that we will collect Medicare deductibles at the beginning of the calendar year.

NAME (PRINT) MEDICARE NUMBER

I request that payment of authorized Medicare benefits be made on my behalf to this office for services furnished me. 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 service.

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

We accept the charge determination of the Medicare carrier as the full charge, and the patient responsibility only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

X_____
SIGNATURE DATE

SECONDARY INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to this office. I understand that I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to this office. I authorize this office to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original

X_____
SIGNATURE DATE

One Center Lane • Levittown, New York 11756
516-579-5400 • Fax: 516-579-5437