SIGNATURE ON FILE

This form is valid until indicated by the signee below in writing of other arrangements.

Name of Patient (print) ____

1) MEDICARE PART B

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Michael T. Ragen, M.D. / Ventura Eye Institute Inc., for services furnished to me by Michael T. Ragen, M.D. / Ventura Eye Institute Inc. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it 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 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 of the information to the insurer or agency shown.

Michael T. Ragen, M.D. / Ventura Eye Institute Inc. accepts the charge determination of the Medicare carrier, Palmetto GBA, as the full charge, and the patient is responsible only for the deductible, coinsurance and non-coverage services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature: _____________________________________ Date:_________________________

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I DO HEREBY CERTIFY THAT I HAVE NO HEALTH INSURANCE OTHER THAN MEDICARE.

Signature: _____________________________________ Date:_________________________

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2) MEDIGAP/INSURANCE COVERAGE IN CONJUNCTION WITH MEDICARE

If a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on the behalf of Michael T. Ragen, M.D. / Ventura Eye Institute Inc.

Signature:_____________________________________ Date:_________________________

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3) PRIVATE INSURANCE ONLY (NO MEDICARE COVERAGE)

I hereby authorize payment of my medical and surgical insurance benefits to Michael T. Ragen, M.D./ Ventura Eye Institute Inc. I understand 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 Michael T. Ragen, M.D. / Ventura Eye Institute Inc. I authorize Michael T. Ragen, M.D. / Ventura Eye Institute Inc. to release any information required to process any and all claims for reimbursement on my behalf. A copy of the authorization may be used in place of the original.

Signature:_____________________________________ Date:_________________________