Insights PA

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Dr. Jeanne Klopfenstein
OD, ABO, FAAO

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Signature On File

Patient Name: _____ **Date:** _____

1. **Medicare:** *I request that payment of authorized Medicare benefits be made on my behalf to Insights, P.A., for services furnished me by Dr. Jeanne Klopfenstein. 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 authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

   Insights, P.A. accepts 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.

Signature: _____ **Date:** _____

2. **Medigap:** *If a Medigap policy or other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes release of information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Insights, P.A.*

Signature: _____ **Date:** _____

3. **Other Insurance:** *I hereby authorize payment of my medical and surgical insurance benefits to Insights, P.A.. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan I agree to pay them Insights, P.A. I authorize Insights, P.A. 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.*

Signature: _____ **Date:** _____