DOSS EYE MEDICAL GROUP

Financial Responsibility Statement: I agree to be personally and fully responsible for payment of all services provided to me by Doss Eye Medical Group. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to the group. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the group. I understand insurance companies generally do not cover vision correction services and may not cover other eye care services. If my account is overdue I may be charged a late payment penalty of the greater of $10 per month or 2% of the outstanding balance per month. In addition, if an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees incurred by the group.

Choice of Health Care Providers: I understand that I may receive preoperative or postoperative care from an group physician or other health care professional, or I may elect to have such care given by a health care professional who is not associated with the group. I understand that, if I want to receive pre- or postoperative care at another location due to geographical distance or other reason, the Group will do its best to recommend a health care professional to me. I understand that the Institute will generally collect payment from me on behalf of non-Group professionals for postoperative care in this case.

I further acknowledge that the recommendation for or against a procedure or other service made by any of the Group's health care professionals will be based on my medical needs and not because I use a health care professional recommended by the Group.

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to the Group, for services furnished me by the Group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for 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. The Group accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

MediGap: I understand that if a health insurance policy is indicated in Item 9 of the CMS-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 on my behalf to the Group, if possible or otherwise to me.

Medi-Cal: I understand that the Doss Eye Medical Group does not accept patients with Medi-Cal insurance under the California Medi-Cal program. By signing below, I attest that I do not have Medi-Cal as my primary or secondary insurance. I agree to be financially responsible for any losses the Group suffers if I make a false statement here.

Release of Information: The Group may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to the Group for reimbursement for services rendered, and (2) any health care provider for continued patient care. The

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Group may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

Other Insurance: I understand that the Group 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 the Group 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 the Group if I belong to a plan that does not appear on the above mentioned list.

Non-covered Services: I understand that the Group's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan, routine eye exams including exams for refractive surgery, comprehensive examination for refractive surgery, premium lens care, and refractions. The undersigned agrees to cooperate with the Group to obtain necessary health care service plan authorizations.

Use of Email and Text Messages: We communicate with you and people in your circle of care by unencrypted email. We may send appointment reminders to you by text message or unencrypted email. If you send us a text message, we may reply by text message. This may allow hackers or others access to your protected health information. We use unencrypted email and text messages because we believe the ease of communication in coordination of care outweighs the potential risk of exposure. If you do not wish for us to communicate with you in these ways, please notify one of the staff members at the front desk.

Surgical Specialty Practice: Doss Eye Medical Group will examine my eyes to determine my suitability for an appropriate eye surgery. I understand that I will not be given a full eye examination to detect the full range of potentially serious eye diseases. I understand that regular eye examinations are an important part of maintaining the health of my eyes, and that I should see my usual eye care professional on a regular basis. The Group can recommend an eye care professional if I wish.

HIPAA Privacy Statement: I acknowledge that I have received a copy of the Group's "Notice of Privacy Practices" as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov.

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I acknowledge that I have reviewed and agree with the foregoing sections entitled, “Financial Responsibility Statement,” “Choice of Health Care Providers,” “Medicare,” “MediGap,” “Release of Information,” “Other Insurance,” “Non-covered Services,” “Consultation (if applicable),” and “HIPAA Privacy Statement,” “Notice to Consumers.”

_____	_____
Patient Name (print)	Date
_____	_____
Signature of Patient, Patient’s Agent or Representative	Relationship to Patient