TEXAS OPHTHALMIC PLASTIC, RECONSTRUCTIVE & ORBITAL SURGERY ASSOCIATES

I HEREBY AUTHORIZE DRS. GILLILAND, VRCEK AND HARRINGTON TO FURNISH MEDICAL AND BILLING INFORMATION TO MY REFERRING PHYSICIAN, OTHER PROVIDERS OF MEDICAL SERVICES, MY INSURANCE PROVIDER(S), AND/OR MY SPOUSE AND/OR GUARDIAN AS NECESSARY TO FACILITATE MY MEDICAL CARE OR TO RECOVER EXPENSES FOR SERVICES RENDERED BY HEALTH CARE PROVIDERS OF THE CLINIC (DRS. GILLILAND, VRCEK AND HARRINGTON). I UNDERSTAND THAT I HAVE THE RIGHT TO SPECIFY, IN WRITING, THAT MY PRIVATE HEALTH INFORMATION BE RESTRICTED FROM DISSEMINATION TO ANY OR ALL OF THE ABOVE.

I HEREBY ASSIGN AND ALL INSURANCE BENEFITS TO DOCTORS GILLILAND, VRCEK AND HARRINGTON TO PAY MY OBLIGATION FOR MEDICAL AND/OR SURGICAL EXPENSES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL CHARGES WHICH MAY BE DENIED OR EXCLUDED BY MY INSURANCE PROVIDERS(S), EXCEPT THOSE CHARGES WHICH ARE EXCLUDED BASED ON MANAGED CARE CONTRACTS BETWEEN THE INSURANCE COMPANY AND DOCTORS GILLILAND, VRCEK & HARRINGTON. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY AN INSURANCE COMPANY. I consent to be photographed, audio/videotaped, recorded, televised or interviewed for medical, scientific or educational purposes. Filming or photographing of an operation or procedure may include appropriate portions of my body. My identity may be revealed by the pictures but not by descriptive texts accompanying them – these photographs/video's and other media may be used for educational purposes only.

In order to provide quality healthcare to all patients who require or desire our services, we strive to participate in all health care plans which offer reasonable and commonly accepted terms. We are participating providers in Medicare, Medicaid and many insurance plans offered in the METROPLEX. To facilitate a good relationship with our patients we have instituted the following policy. We are providers of medical services, not an insurance company, bank or financial institution. THEREFORE, we expect payment for services rendered and require the patient to ensure that we are paid promptly for all services rendered.

For patients covered by insurance with which we are contracted we will collect deductibles and co-pays as outlined by your insurance plan at the time of service. Patients scheduling surgery may be required to pay estimated co-pay prior to surgery.

We will file all claims and paper work with your insurance company as contractually allowed. If the insurance company does not pay a claim within the required time (usually 45 days) the patient will become responsible for the bill. Should you receive a bill from our office for services that should have been paid by an insurance company, it is only after we have exhausted all efforts pursuing your claim with your insurance company. All charges are the patient's responsibility regardless of insurance benefits. Bill's received from our office must be paid within 15 days from the date of the statement. We do charge an interest rate of 18% annually for balances not paid within 15 days of the billing date. All accounts over 90 days old will be referred to an outside collection agency, attorney's office or credit bureau. In addition, the patient/responsible party agrees to be responsible for the fees of any collection agency and all costs and expenses, including reasonable attorney's fees, we incur at the time of the collection efforts. This will be added at the time the account is sent for collection. If your insurance company/network/exchange etc. should recoup or deny fees, for any reason, after a service has been provided, you will be responsible for the entire bill plus applicable interest charges. We charge for filling out disability claim forms and any and all paperwork required by the patient or insurance company. Non-emergency phone calls may be billed at our discretion.

For patients covered by insurance with which we are **NOT** contracted, we will collect payment for office visits at the time the service is provided. Patients scheduling surgery will be required to pay a **deposit** prior to surgery – usually 65% of estimated surgery charges. We do expect to be paid 100% of billed charges for surgery. Patients may receive all or part of their deposit back depending upon insurance company payment (i.e. if the total payment by patient and insurance company exceeds 100% of billed charges). We will file the insurance claim for surgery as a convenience to you. It is the patient's responsibility to provide all necessary paper work to their insurance company and to ensure that their insurance company pays our claims in a reasonable and timely manner. Should additional surgery be required after initial treatment, the patient (or their insurance company) will be charged for all additional treatments (as they were for the initial treatment). This includes surgeon's fees, anesthesia fees and facility fees.We do charge a $75 cancellation/no show fee if not notified 2 business days prior to an office appointment. In addition, we charge a $250 cancellation/no show fee for surgical

appointments if not notified 5 business days prior to the appointment.

For patients with outstanding balances in our office, we expect these balances to be paid prior to scheduling any further procedures – unless other arrangements are made with our office.

If your insurance, carrier, including Medicare, determines that a service is not a covered expense it will deny payment. As your physician, I may feel that a particular service is in your best interest. If Medicare or your insurance carrier does not pay for this service for any reason including but not limited to: not being a covered benefit, not deemed medically necessary or cosmetic in nature – you are fully responsible for payment. This also includes partial payment by your insurance carrier. By signing BELOW, you agree to accept full financial responsibility for any service denied by your insurance carrier.

PRINT NAME _____

SIGNATURE _____

DATE _____