Maria Florio Jablonski, OD, LLC
110 Atwood Avenue
Cranston, RI 02920
Phone: (401) 943-4770 Fax: (401) 490—0909

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Notice

Beneficiary Name (Print): Medicare #:

☐ **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Maria Florio Jablonski, OD for services furnished me by Dr. Jablonski. 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 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, my signature authorizes releasing the information to the insurer or agency shown. Maria Florio Jablonski, OD 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 MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form, 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 Maria Florio Jablonski, OD, if possible or otherwise to me.

☐ **OTHER INSURANCE:** I authorize payment of my medical insurance benefits to Maria Florio Jablonski, OD. I understand I am financially responsible for any charges whether 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 Maria Florio Jablonski, OD. I authorize Maria Florio Jablonski, OD 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.

☐ **NON-COVERED SERVICES:** I understand that Maria Florio Jablonski, OD's contract with health care services plans relates only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. I agree to cooperate with Maria Florio Jablonski, OD to obtain necessary health care service plan authorizations.

☐ **FINANCIAL AGREEMENT:** I agree that in return for the services provided to me by Maria Florio Jablonski, OD, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Maria Florio Jablonski, OD for payment. I f my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I also understand I will be responsible for any fees for insufficient fund returned checks. Any benefits of any type under any policy of insurance are hereby assigned to Maria Florio Jablonski, OD. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Maria Florio Jablonski, OD. **However, I understand that I am primarily responsible for the payment of my bill.**

☐ **HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have been offered or received the Notice of Privacy Practices issues by Maria Florio Jablonski, OD that was effective April 25, 2017.

Print Name: Sign Name:

Beneficiary Signature or Authorized Party **Date:**