Medical Consent and Payment Policy

This is a continuing "signature on file" agreement and is valid until revoked by patient in writing.

1. **CONSENT FOR EXAMINATION:** "I hereby voluntarily present myself to Coastal Cape Fear Eye Associates, PA (Hereafter known as CCFEA) for examinations, treatment and medical procedures and do hereby consent to such medical services as discussed with my doctor and may be deemed medically necessary."

2. **MEDICARE, MEDICAID,MEDIGAP,CHAMPUS, OR OTHER GOVERNMENTAL Agency:** "I request that payments of authorized benefits be made on my behalf of Medicare, Medicaid, Medigap, Champus or other governmental agency to be paid directly to CCFEA for medical services furnished to me by their physicians. I understand that I am responsible for any deductible and co-insurance of allowable charges not otherwise covered." "I am hereby notified by CCFEA that the above carriers or agencies will deny payment for routine exams and procedures that are not medically necessary. Some of these procedures may include Fluorescein angiograms, PAM testing, Refraction, Fundus photos, Visual fields, External photos and Blepharoplasty. I agree to be personally responsible in such cases."

3. **PATIENTS WHO ARE COVERED BY A GROUP OR PRIVATE INSURANCE that we file:** "I assign and authorize CCFEA to submit a claim to my insurance carrier(s) or their agents to pay CCFEA." "I understand that I remain financially responsible for CCFEA for any and all charges not met by the proceeds of the assignment and for all charges should said proceeds not be paid within a reasonable time (45 days) after charges are filled with the carrier or should the carrier deny or reduce payment below the CCFEA charge." "I am hereby-notified by CCFEA that insurance carriers will deny payment for routine exams or tests where there are no symptoms or positive findings." They can also determine that certain exams and tests are not "medically necessary." Some of these procedures may include Fluorescein angiograms, PAM testing, refractions, Fundus photos, Visual fields, External photos, and Blepharoplasty.

4. **RESPONSIBILITY FOR PAYMENT (NO INSURANCE COVERAGE):** "Patients are to pay all charges on the date of service unless other arrangements have been made in advance with our Office Manager. I understand that I am personally responsible for any and all charges for my office visit and related charges."

5. **WAIVER OF LIABILITY:** "I understand that I will be responsible for full payment for services that I received from CCFEA that have not been authorized by my primary care physicians and for services from which I have chosen to go out of the network."

6. **CONSENT CERTIFICATION:** "I certify that I have reviewed this form and understand its contents. I also understand that this is a continuing "Signature on file" agreement that is valid until canceled by me (the patient) in writing and that I have a right to receive a copy upon request."

_____	_____	_____
Signature of patient or guardian (if patient is minor)	**Relationship to patient**	**Date**