OPHTHALMIC PLASTIC SURGERY, PLLC

Edward J. Wladis, MD/Michael I. Rothschild/Dale R. Meyer, MD/Charlotte L. Marous, MD

Financial Agreement and Assignment of Benefits

For Medicare or Senior Advantage
I request that payment of authorized Medicare benefits be made on my behalf to **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)** for services furnished me by **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)**. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms, my signature authorized releasing to the insurer or agency shown.

Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous) accepts the charge determination of the Medicare carrier, Blue Shield of Western NY, or applicable DMERC, as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

For Medigap
I understand that if Medigap policy or other health insurance is indicated in item 9 of the HCFA-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 benefits be made on my behalf to **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)**.

For Other Insurance
I hereby authorize payment of my medical and surgical insurance benefits to **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)**. I understand that I am financially responsible for any charges, whether or not paid by said insurance. If co-payment and/or deductible are designated by my insurance company or health plan, I agree to pay them to **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)**. I authorize **Ophthalmic Plastic Surgery (Doctors Edward J. Wladis, Michael I. Rothschild, Dale R. Meyer and Charlotte L. Marous)** to release any information required to process any and all claims for reimbursement on my behalf. A copy of the authorization may be used in place of the original.

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Beneficiary Signature or Authorized Party   Date

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Beneficiary Name (Print)