AUTHORIZATION TO FILE CLAIMS WITH INSURANCE

MEDICARE PATIENTS

I request that payment of authorized MEDICARE BENEFITS be made on my behalf to Sedalia Eye Associates, P.C. for any services furnished. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I have been notified by my physician that if Medicare denies payment for services, for any reason, I agree to be personally and fully responsible for payment.

_____ _____

Signature of Insured Date Signed by Insured

PRIVATE AND/OR SECONDARY INSURANCE PATIENTS

I request that payment of authorized benefits be made on my behalf to Sedalia Eye Associates, P.C. for any services furnished. I authorize any holder of medical information concerning me to be released to my insurance carrier and its agents. Any information needed to determine these benefits for related services. I have been notified by my physician that for any reasons my insurance company denies payment for these services for any reason, I agree to be personally and fully responsible for payment.

_____ _____

Signature of Insured Date Signed by Insured

NONPAYMENT/BREACH

RETURNED CHECK FEE - A charge of $30.00 will be made by Sedalia Eye Associates, P.C. for any check or other negotiable instrument tendered by you and returned unpaid by a financial institution for any reason; and Sedalia Eye Associates, P.C. may demand payment by money order, cashier's check or similar secure form of payment, at Sedalia Eye Associates, P.C.' discretion.

NONPAYMENT POLICY - If Sedalia Eye Associates, P.C. obtain the services of a collection agency or attorney to assist in remedying your nonpayment, the expense of this fee will be paid by you.

_____ _____

Signature of Patient or their Authorized Representative Date