



**Guarantor Information** (Person responsible for payment if different from self):

Name: \_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
First Last M M D XXXX  
Address: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

**Additional information:**

Are you a year round resident of Florida?  Yes  No If no, please check the months you reside in Florida:  
 Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec

**Second Address:** \_\_\_\_\_  
Street Address City State ZIP

**Alternate Phone:** ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

**OFFICE POLICY REGARDING PAYMENT:**

Please read over the following information very carefully before seeing the doctor. This is to eliminate any confusion regarding office policies. Thank you!

**Medicare:** We accept Medicare assignment. Medicare assignment means we will be reducing our fees to the Medicare allowed amounts. Medicare will pay 80% of the allowed amount leaving 20% co-payment to your responsibility. As a courtesy, we are happy to file your supplement to your secondary insurance for you. However, if your supplement pays directly to you, you will be responsible for the 20% today plus any non-covered services (example: refractions).

Medicare has a deductible of \$100.00 per calendar year. You are required by Medicare to pay the first \$100.00 for any outpatient medical expense if you have not met your deductible.

**Medicaid:** You are responsible for a \$2.00 co-payment at the time services are rendered.

**Managed Care Plans (HMO or PPO):** Your plan requires you to pay your co-pay at the time of service. HMO plans are required to have an authorization number or referral slip from your primary care physician. If this is not obtained **prior** to your visit, you will be responsible for full payment at the time services are rendered.

**Private/Commercial/Group Insurance:** You are responsible for payment of services today unless a surgical procedure is performed. This is the only instance in which we file this type of insurance. You will be provided with an itemized receipt to file to your insurance company.

**No Insurance:** Unless prior arrangements have been made with our office, full payment is due at the time services are rendered.

**Refractions are non-covered services with most insurance companies – Medicare & Medicare HMOs included. You are responsible for payment of such at the time of service.**

I have read the above office policy completely. I understand and accept this policy. I also understand that I am fully and legally responsible for payment of this account, which includes outstanding balances not covered by Medicare and/or insurance companies. In the event that I fail to pay the outstanding balance, I also agree to pay all billing charges, costs of collection agency fees, attorney fees and court costs, if any.

\_\_\_\_\_  
Patient/Guardian/Guarantor Signature

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
M D 20XX

\_\_\_\_\_  
Witness