



SIGNATURE ON FILE

Please check the appropriate box(es):

Financial Responsibility Policy – Excluding Medicare

Dr. Friedman’s office has advised me that they DO NOT participate with my insurance. My decision to have care acknowledges this fact. I understand that his office will do their best to facilitate the processing of my claim, but that *I am responsible for all professional services at the time of service.*

Medicare Policy

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administrative and Health Care Financing Administrations or its intermediaries or carrier, or to the billing agent of this physician or supplier which is Robert Friedman, M.D., any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Medicare does NOT cover refraction, i.e., the prescribing of spectacles. The physician is expected to charge the patient directly for these services. *The fee for this service is \$80.00 per encounter.*

Medicaid Policy

I acknowledge that I am fully aware of my rights and privileges as a Medicaid enrollee, and that I do understand that I can receive the medical service that I am commissioning from Robert Friedman, M.D. for free or reduced costs by seeking attendance from a participating provider.

I request that Dr. Robert Friedman provide me with medical services at the costs stated by his office and recognize that *I will be personally responsible for these expenses at the time of services.* These charges will NOT be submitted to Medicaid or any authorized agency and are not eligible for reimbursement by any agency.

I authorize Dr. Friedman’s office to collect the above stated fees by all conventional methods.

HIPAA (Health Information Portability and Accountability Act)

I reviewed the HIPAA Notice of Privacy Practices that is displayed and operative in the office of Robert Friedman, MD, PC.

By signing below I hereby acknowledge that I have read and understood all of the above policies.

X _____

Date: 07/22/2016