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

Name: _____ _____ _____ SSN: _____-____-_____ Birth: ____/____/_____
First MI Last M D YEAR

Address:_____ Relationship to patient:_____

Employer:_____ Phone: (_____) _____-_____

Additional information:
Are you a year round resident of Florida? YES / NO If no, please check the months that 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 Number: (_____) _____-_____

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!

Insurance is a contract between you and your insurance company. We are not a party to this contract. We bill participating insurance companies as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

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 you with the 20% co-payment to your responsibility. As a courtesy to you we will happily file your supplement to your secondary insurance company should you have one, however if your supplement pays directly to you, you will be responsible for that 20% today plus any non-covered services (example: refractions). Medicare has an annual deductible per calendar year which you are required by Medicare to pay, and your 20% co insurance for any outpatient medical expense as well.

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 a non-covered service with most insurance companies – Medicare & Medicare HMOs and secondary insurances 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 on this account, which includes outstanding balances not covered by Medicare and or other 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'S OR AUTHORIZED SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits either to myself or to the party who accepts this assignment.

FOR MINORS: I give my permission for my child to be treated by Michael J. Collins, Jr. M.D., F.A.C.S.

X_____ Date: _____/_____/_____
Patient/ Parent or Guardian Signature M D YEAR

_____
Witness