

MALONEY VISION INSTITUTE®

Financial Responsibility Statement. I agree to be personally and fully responsible for payment of all services provided to me by Robert K. Maloney MD, Inc. dba Maloney Vision Institute, a Medical Corporation (the "Institute"). Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to the Institute. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the Institute. I understand insurance companies generally do not cover vision correction services and may not cover other eye care services. If my account is overdue I may be charged a late payment penalty of the greater of \$10 per month or 2% of the outstanding balance per month. In addition, if an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees incurred by the Institute.

Choice of Health Care Providers. I understand that I may receive preoperative or postoperative care from an Institute physician or other health care professional, or I may elect to have such care given by a health care professional who is not associated with the Institute. I understand that, if I want to receive pre- or postoperative care at another location due to geographical distance or other reason, then, upon my request, the Institute will do its best to recommend a health care professional to me. I understand that the Institute, as a courtesy to me, may agree, in its discretion, to collect payment from me on behalf of non-Institute professionals.

I further acknowledge that the recommendation for or against a procedure or other service made by any of the Institute's health care professionals will be based on my medical needs and not because I use a health care professional recommended by the Institute.

Medicare. I request that payment of authorized Medicare benefits be made on my behalf to the Institute, for services furnished me by the Institute. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The Institute accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

MediGap. I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-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 insurance benefits be made on my behalf to the Institute, if possible or otherwise to me.

Release of Information. The Institute may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to the Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care. The Institute may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the

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collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

Other Insurance. I understand that the Institute maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that the Institute has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by the Institute if I belong to a plan that does not appear on the above mentioned list.

Non-covered Services. I understand that the Institute’s contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient’s contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan, routine eye exams including exams for refractive surgery, comprehensive examination for refractive surgery, premium lens care, and refractions. The undersigned agrees to cooperate with the Institute to obtain necessary health care service plan authorizations.

Vision Correction Consultation (if applicable). If my scheduled visit today is for a complimentary consultation for vision correction surgery, I will be examined to determine my suitability for vision correction procedures. I also understand that I will not be given a full eye examination to detect potentially serious eye diseases. I understand that regular eye examinations are an important part of maintaining the health of my eyes, and that I should see my usual eye care professional on a regular basis. The Institute has advised me that it can either provide these services for a fee or recommend another eye care professional if I prefer.

HIPAA Privacy Statement. I acknowledge that I have received a copy of the Institute’s “Notice of Privacy Practices” as required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Notice to Consumers. Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov.

I acknowledge that I have reviewed and agree with the foregoing sections entitled, “Financial Responsibility Statement,” “Choice of Health Care Providers,” “Medicare,” “MediGap,” “Release of Information,” “Other Insurance,” “Non-covered Services,” “Consultation (if applicable),” and “HIPAA Privacy Statement,” “Notice to Consumers.”

Patient Name (print)

Date

Signature of Patient, Patient’s Agent or Representative

Relationship to Patient