MEDICARE & INSURANCE AUTHORIZATION and RELEASE OF INFORMATION

DATE: _____/_____/_____ CHART #: _________ NAME: _________________________________

I. PAYMENT OF INSURANCE BENEFITS

I request that payment of authorized Medicare or Insurance benefits be made to Retina Consultants, PLLC for any service furnished to me by any authorized provider of Retina Consultants, PLLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or my insurance company any information, written or oral, needed to determine these benefits or the benefits payable for related services.

II. CONCERNING INSURANCE

Patients who carry health care insurance should remember that professional services are rendered and charged to the patient and not to the Insurance Company. Although our office may accept the type of insurance you have, that does not mean that we are in network with your company. This may mean that you will have a balance that your insurance does not cover and you will be billed for that amount.

COPAYMENTS ARE REQUIRED AT THE TIME OF VISIT - THIS INCLUDES SECONDARY INSURANCE COPAYMENTS.

All patients are asked to pay a minimum of 20% of the charge at the time of service. A refund will be given any time an insurance company pays the full amount.

This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account within the limits of our financial policy. Our Accounts Manager is available to answer any questions you may have.

III. DISCLOSURE OF HEALTH INFORMATION

1. I understand that my individually identifiable health information may be used and disclosed to carry out treatment or health care operations.
   a. We may provide your health care providers with your health information to assist him or her in treating you. A letter explaining your condition will be mailed, faxed or emailed to your referring physician and/or medical doctor after your examination.
2. I understand that the Notice of Privacy Practices provides a more complete description of the type of uses and disclosures and that I should review the Notice and acknowledge that I received it before signing this consent.
3. I understand Retina Consultants, PLLC reserves the right to change the terms of the Notice and to apply the revised practices to health information already maintained. Any revision to the Notice will be described in a revised Notice that will be posted prominently in our facility.
4. I understand that I may request that the covered entity restrict how my individually identifiable health information is used or disclosed to carry out treatment, payment or health care operations. The covered entity is not required to agree to requested restrictions, but if the covered entity agrees to a requested restriction, the restriction is binding on the covered entity.
5. I understand that I may revoke the consent at any time by notifying the covered entity in writing, except to the extent the covered entity has taken action in reliance on the consent.
6. I understand that I do not have the right to revoke the authorization if it was obtained as a condition of obtaining insurance coverage another applicable law provides the insurer that obtained the authorization with the right to contest a claim under the insurance policy. If I choose to revoke the authorization, I understand that I may be denied treatment or eligibility for benefits. I also understand that revocation will not apply to information that has already been released in response to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

(continued on next page)

____
Patient initials

MEDICARE & INSURANCE AUTHORIZATION and RELEASE OF INFORMATION CONTINUED

DATE: _____/_____/_____ CHART #: _________ NAME: ________________________________

IV. Release of information to family members/caregivers

Information regarding a patient's ocular/systemic medical conditions is to be held confidential between a patient and the physician-staff. Often we receive phone calls from family/caregivers regarding a patient's ocular and related medical condition. This typically arises from confusion regarding their understanding of the condition or an attempt to understand current and future needs of the individual. Often transmission of information better allows us as well as family/caregivers to assess and assist in the overall management of a patient's condition/situation.

I understand my right as a patient to have all information concerning my ocular and related medical condition to be held strictly confidential. I give Retina Consultants, P.L.L.C. permission to: ***(please check one and provide a list of specific family members or caregivers)***

☐ Discuss my ocular/medical condition with the following family/caregivers (include phone number):

____

____

☐ I request that ***no*** information be transmitted to family/caregivers **without my prior authorization**.

I understand it is my responsibility to let Retina Consultants know if I wish to make any changes to the above information.

I acknowledge that I have read the above and understand the foregoing and consent to all 4 sections.

____ ____________________

SIGNATURE OF PATIENT (LEGAL REPRESENTATIVE) **DATE**