Retina associates

Comprehensive diagnostic and surgical care of the retina, macula and vitreous

## Financial Responsibility Statement/Release of Information Authorization

### MEDICARE

I request that payment of authorization Medicare benefits be made to Retina Associates on my behalf for any services furnished me by their physician. I authorize and holder of medical information about me to release to the Health Care Financing Adminstration and its agents any information needed to determine these benefits payable for related services.

### Medicare Supplement

I request that payment of authorization Medigap benefits be made on my behalf to Retina Associates for any services furnished me by their physicians. I authorize any holder of medical Information about me to release to my insurance any medical information needed to determine these benefits or the benefits payable for related services.

### Private Insurance

I authorize Retina Associates to furnish information to insurance carriers concerning the illness or medical treatment of my dependent or myself; and I hereby assign to the provider(s) all insurance payment for medical services rendered to myself/or my dependent. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

### HMO/PPO/POS

I understand that I am responsible for obtaining a referral, referral number, authorization number and/or precertification number for all visits/services performed by Retina Associates, and its physicians. If my HMO/PPO managed care plan denies payment due to lack of required referrals, referral numbers, authorization numbers, and/or precertification numbers, I agree to be personally and fully responsible for payment.

Signature of Patient or Responsible Party: _____

Date: _____