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ASSIGNMENT OF BENEFITS AND AUTHORIZATION OF RELEASE INFORMATION

I authorize the release of my medical records and clinical information to any health insurance company and/or Medicare/Medicaid for the purpose of processing and paying insurance or disability claims.

I hereby assign all medical and/or surgical benefits from my insurance company and/or Medicare/Medicaid to Retina Vitreous Consultants for services rendered. I authorize any holder of medical information regarding me to release to the insurance company/organization and/or Health Care Financing Administration and its agents who administer my benefits any information needed to determine these benefits or the benefits payable for related services.

This authorization will remain in effect until revoked by me in writing. A photocopy of this assignment of benefits is considered as valid as the original. I understand that I am financially responsible for all charges not paid to the physician by the insurance company in accordance to each company or organization's contract with Retina Vitreous Consultants and in accordance with the rules set forth by Medicare/Medicaid guidelines. I understand that if the physician is not contracted by or participating with my health plan, I am responsible for the fee charged. I understand that even though the physician may not be participating with my health plan that Retina Vitreous Consultants will bill my insurance as a courtesy to me. I authorize Retina Vitreous Consultants to release all information necessary to secure payment for services rendered.

Patient Signature:_____ Date:_____

Print Patient Name:_____

Legal Guardian
Or Power of Attorney_____ Date:_____
(Signature)

To sign as Power of Attorney, please provide a copy of the Power of Attorney document

Print Name of Legal Guardian or
Power of Attorney:_____

Relationship to Patient:_____