PAMELA GOLCHET, MD
DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY
DISEASES OF THE RETINA & VITREOUS

RELEASE & ASSIGNMENT OF BENEFITS

Patient's Name: _____ Account No. _____ DOB: _____ /____ /_____

A. Medicare

I request that payment of authorized Medicare benefits be made on my behalf to *Visionary Retina Center* for services furnished to me by *Visionary Retina Center*. 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 the 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. *Visionary Retina Center* 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.

B. MediGap

I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS1500 form or elsewhere on other approved claim forms, my signature authorizes the 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 *Visionary Retina Center*.

C. Release of Information

Visionary Retina Center 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 Visionary Retina Center* for reimbursement for services rendered, and (2) any health care provider for continued patient care. *Visionary Retina Center* 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 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.

D. Other Insurance

Visionary Retina Center is committed to providing our patients with cost-effective care. *Visionary Retina Center* accepts most major insurances and will directly bill your insurance carrier. We ask that you verify your benefits and eligibility with our office before your initial visit. Any co-payments or deductibles required by your insurance provider must be paid on the date of your office visit. You are responsible for

payment of all services that are not covered by your insurance plan. Any balance not covered is due within 30 days of your scheduled appointment. We accept patients who do not have insurance and are self-pay. I understand that *Visionary Retina Center* maintains a list of healthcare service plans with which it contracts and can be obtained from our office or can be found on our website (www.VisionaryRetina.com). *Visionary Retina Center* 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 *Visionary Retina Center* if I belong to a plan that does not appear on the above-mentioned list.

E. Non-Covered Services

I understand that *Visionary Retina Center'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. The undersigned agrees to cooperate with *Visionary Retina Center* to obtain necessary health care service plan authorizations

PATIENT:	_____	_____	_____
	SIGNATURE	PRINT NAME	DATE
WITNESS:	_____	_____	_____
	SIGNATURE	PRINT NAME	DATE