RETINA SPECIALISTS

Please Print Date: ____________________

Patient's Name: ______________________________ Phone#: ____________________

Patient's Address: ____
street city state zip

Second Address or Mailing Party: ____
street city state zip

Patient's Age: _____ Date of Birth: ___________ Social Sec. #: ___________________

Marital Status: S M W D (Circle One) Sex: M F (Circle One) Spouse's Name: ______________________

Spouse's Soc. Sec. #: ___________________

Spouse's Date of Birth: _______________

Employer's Name and Address: ____________________________________ Phone#: ___________________

Spouse's Employer's Name and Address: ____________________________________ Phone#: ___________________

Person Responsible for Bill: ____

Doctor's Name That Referred You To Us: ______________________________________

Your Medical Doctor's Name: ____

PLEASE TURN OVER THIS FORM AND SIGN THE BACK

LIFETIME AUTHORIZATION

Medicare or Insurance Certification for Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician services to the physician or organization furnishing the services.

I request that this authorization also apply to any insurance other than Medicare. I also request that payment of authorized MEDIGAP/Supplemental benefits be made on my behalf to Retina Specialists for any services furnished me by physicians of Retina Specialists. I authorize any holder of medical information about me to release to Retina Specialists and/or MEDIGAP/Supplemental insurer any information needed to determine these benefits or the benefits payable for related services and/or to aid in my medical care.

INSURANCE DISCLAIMER: Due to the many different kinds of insurance companies, you are required to know your insurance coverage. Payment for all services rendered is your responsibility. This also applies to you if you choose to use an out of network physician at our facility under your HMO/PPO plan. I also, understand by signing, I am guaranteeing payment of this account (if insurance is billed and doesn't pay as well). Failure to pay on this account within 120 days will result in collections fees applied to this account balance, if any.

INFORMATION REGARDING DILATING · EYE DROPS

DILATION IS THE STANDARD OF CARE TO ALLOW THOROUGH EVALUATION OF EYE TISSUE FOR A NUMBER OF EYE CONDITIONS. The use of dilation drops temporarily increases the size of your pupils, which allows an eye physician to more accurately investigate the health of your eyes. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected, and because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. For a short time, wearing sunglasses may be a necessary comfort. Adverse reactions, such as acute angle-closure glaucoma may also be triggered and/or diagnosed by the dilating drops. Call our office immediately if you experience excessive pain, discomfort, nausea, or any other untoward symptoms. Thank you for your assistance during this important procedure.

By signing this form I hereby acknowledge that I am aware of the above information and authorize my physicians and/or their assistants to administer dilating eye drops to assist in the optimum evaluation of my eyes. My acknowledgement and authorization shall be without expiration, but I am aware that (as all other diagnostic or treatment procedures) AT ANY TIME I MAY ELECT TO NOT HAVE THIS IMPORTANT PROCEDURE BY SIMPLY INFORMING THE TECHNICIAN AND/OR PHYSICIAN. If I elect to not use dilating drops for my examination, I also hereby affirm that I am aware that my decision may reduce the ability of my physician to optimally care for my eyes.

______________________________ Date ______________

Signed by Patient (or person authorized to sign for patient)

Medigap/Supplemental Signature: ______________________________

By: Self or * ______________________________ Relationship ______________

______________________________ Date ______________

Witness

* If signed by other than beneficiary, state the reason patient was unable to sign:

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