

RETINAL AND OPHTHALMIC CONSULTANTS, PC

General policies and release of information

Please read the following very carefully. By reading and signing this document you agree to adhere to the subject of each item.

INSURANCE, REFERRALS AND FINANCIAL RESPONSIBILITY

It is my responsibility to provide Retinal and Ophthalmic Consultants, PC with my current insurance cards and any referrals that are necessary. I understand that I am financially responsible for all charges whether or not paid by insurance. The extent of my financial responsibility may be limited by the contractual relationship with my insurer.

ASSIGNMENT OF BENEFITS

I authorize payment of medical and or surgical benefits for services provided, including benefits to which I am entitled, to Retinal and Ophthalmic Consultants, P.C. This assignment will remain in effect until evoked by me in writing.

RECORD RELEASE

I authorize release of my complete medical records to or from other doctors who share in my care, my insurance companies (and their intermediaries or carriers), and to my attorney. This release includes information that may be considered sensitive, such as (but not limited to) present or past HIV status, sexually transmitted diseases, abortions, hepatitis, alcohol use or psychiatric treatment. A photocopy of this assignment and authorization is to be considered as valid as an original.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Retinal and Ophthalmic Consultants may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. I reserve the right to review Retinal and Ophthalmic Consultants' Notice of Privacy Practices prior to signing this consent for a more complete description of such uses and disclosures.

CO-PAY AND BILLING SERVICE FEE

I understand that if my insurance requires a co-pay it is my responsibility to provide the co-pay at the time of check-in. I also understand that if my co-pay is not paid at the time of my appointment a \$10.00 billing service fee will be applied to my account. My insurance company will not cover this fee.

RETURNED CHECKS

I understand that if for any reason a check is returned for non-payment I will be charged a \$25.00 returned check fee. My insurance company will not cover this fee.

PUPIL DILATION

I understand that my vision may be blurry after my examination, testing or treatment. Retinal and Ophthalmic Consultants recommends that you do not drive after your appointment, please arrange for transportation.

PHOTOGRAPHS AND OTHER IMAGES

As part of my eye care, testing may be performed. This includes but is not limited to ultrasound, photographs, retinal scans and visual fields. Any images, videos or other medical information obtained from these tests are the property of Retinal and Ophthalmic Consultants, P.C. and my doctors. They may use this material for educational and any other purpose as long as my identity cannot be determined or directly implied from these materials.

MINORS/POWER OF ATTORNEY

All patients who are not 18 or older must have a parent or legal guardian present with them through each appointment. Patients who have a designated power of attorney (POA) for Healthcare and Legal POA must provide documentation of POA and must sign this form for the patient. The POA must also provide us with their name, address and phone number.

These policies may change from time to time. Current office policies are available upon request.

Signature of Patient or POA Print patient name Date of Birth Date

POA name, address and phone (if applicable)