VITREO-RETINAL ASSOCIATES PC

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AUTHORIZATION TO NOT BILL HEALTH INSURANCE AND RESTRICT DISCLOSURE OF PROTECTED HEALTH INFORMATION TO HEALTH INSURANCE

I, ______________________________________, with my date of birth being ______________, hereby request that no claim for benefits under my health insurance policy be submitted for assignment and payment to Vitreo-Retinal Associates, PC for my visit on __________________.

I understand that I am fully responsible for all charges for services rendered by Vitreo-Retinal Associates, PC for this date of service and that all such charges are due, in full, on the date of service.

I understand that there will be no discount for any charges on this date of service and that I will be charged the current Medicare reimbursement rates.

I understand that no claim shall be submitted to my insurance carrier in order to satisfy my deductible.

I understand that, within 30 days of my date of service, I have the right to revoke my request to not have claims submitted after this appointment and that, upon such revocation and my request to submit such claims to my insurance carrier, if Vitreo-Retinal Associates, PC receives payment for such services, any payment I made for that date of service will be returned to me after they receive payment in full.

I understand that my insurance carrier may deny me benefits for any condition that may arise due to lack of documentation as I elected not to utilize my insurance benefits.

With my signature below, I agree that I have read and fully understand the conditions outlined above and have no further questions.

___________________________________ ___________________________________

Patient's Signature Witness Signature

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Date