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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

Date