AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO:

RETINA CARE SPECIALISTS

DR. MARK MICHELS-DR. ADRIAN LAVIÑA- DR. PAUL GALLOGLY- DR. PHILIP LAIRD

NAME OF PATIENT:

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I HEREBY AUTHORIZE RETINA CARE SPECIALISTS TO RELEASE INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT TO MY INSURANCE COMPANY. I HEREBY ASSIGN PAYMENT DIRECTLY TO RETINA CARE SPECIALISTS FOR ANY EXAMINATION, DIAGNOSTIC TESTING OR MEDICAL PROCEDURES PERFORMED. I AGREE THE AUTHORIZATION SHALL BE VALID UNTIL RESCINDED IN WRITING OR REPLACED BY ONE OF A LATER DATE. I RECOGNIZE, UNDERSTAND AND ACCEPT THAT I AM FINANCIALLY RESPONSIBLE TO THE DOCTORS FOR ALL CHARGES, BALANCES OR FEES NOT COVERED IN THE EVENT THAT I HAVE NO INSURANCE, MY INSURANCE IS REJECTED OR THE DOCTOR IS OUT OF NETWORK. I AGREE THAT I WILL HAVE NO RECOURSE TO RECOUP SUCH FEES FROM STATE, FEDERAL OR HEALTH CARE ORGANIZATIONS. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLE OR COPAYMENT, AND THAT THESE ARE DUE AT THE TIME THAT SERVICES ARE RENDERED.

I UNDERSTAND THAT IF MY ACCOUNT IS NOT SETTLED WITHIN THE 90 DAYS THAT SERVICES ARE RENDERED, RETINA CARE SPECIALISTS MAY ELECT TO CHARGE INTEREST ON MY ACCOUNT AT THE MAXIMUM ALLOWED BY THE LAW.

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PATIENT SIGNATURE WITNESS DATE