Authorization for Claims Payment and Reviews

1. **For Medicare Recipients:**
   I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to The Retina Centers of Washington for any services rendered to me during the applicable period of medical care.

2. **Assignment and Coordination of Insurance Benefits:**
   I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to The Retina Centers of Washington for services rendered to the patient. I hereby authorize payments directly to The Retina Centers of Washington, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to The Retina Centers of Washington for services rendered to me during the applicable period of medical care

3. **Unauthorized, Non-covered, or Out-of-Network Services:**
   I understand that if my insurance carrier or administrator of benefits does not cover any services rendered a covered service or has not authorized these services, they will not pay, and I agree to pay for these services. I also understand and acknowledge that in the case of out-of-network/plan, there may be reduced benefits and I may be required to pay a higher patient responsibility (co-pay, co-insurance, deductible) amount. I also understand and acknowledge that in the event that a Primary Care Physician's (PCP) referral is required for my visit, I/the patient am responsible for obtaining such document and will be required to sign a PCP Referral waiver form prior to being seen, if a PCP Referral has not been obtained prior to my scheduled appointment.

4. **Authorization to Release Information:**
   I hereby authorize The Retina Centers of Washington to release any information acquired during the course of my medical care necessary to process insurance claims and or follow-up for healthcare operations and securing payments for services rendered.

5. **Responsibility for Payment:**
   In my capacity as a patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible for including, but not limited to, health benefits deductibles, copayments, co-insurances, and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payments, I agree to pay reasonable attorneys' fees and other collection costs.

6. **Automobile Accident Patients:**
   I hereby understand that information about the automobile accident must be provided to The Retina Centers of Washington prior to my scheduled appointment. In the event that such information is not available, I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to The Retina Centers of Washington for services rendered to the patient. I hereby authorize payments directly to The Retina Centers of Washington, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to The Retina Centers of Washington for services rendered to me during the applicable period of medical care.

By signing below, I certify I have read and understand the foregoing; having had the opportunity to ask questions and have them answered and accepted the above conditions and terms; and I agree to pay all charges for which I may be legally responsible for including, but not limited to health insurance co-payments, Co-insurances, deductibles, and non-covered services. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' and other collection costs insurance by The Retina Centers of Washington. I understand and agree that this document will remain in effect for my present and future physician office visits to The Retina Centers of Washington, unless specifically rescinded in writing by me.

Patient Name: _____ **Date: _____**

Patient Signature: _____

NOTICE: Patients are not required to complete this assignment of benefits form. If you do not complete this form, all charges are your responsibility and will be due at the time of service.