

SIGNATURE ON FILE

I request that payment of authorized benefits be made on my behalf to Long Island/Queens Vitreoretinal Consultants and/or its providers for services furnished to me. I authorize any holder of medical information about me to release to Empire Medicare Services or any other of my medical carriers any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of original.

1) SIGNATURE _____ Date: _____

PRIVACY POLICY I have received the Notice of Privacy (HIPAA).

2) SIGNATURE _____ Date: _____

CONSENT TO RELEASE INFORMATION:

I permit you to release any medical information to the physicians involved in my care. I consent to the practice calling my home or other designated location and leaving a message on voice mail or in person in reference to appointment reminders and insurance items. In addition, the practice may mail to my home appointment reminders and patient statements.

3) SIGNATURE: _____ Date: _____

I designate the following representative(s) who the provider can communicate with on my behalf (example, spouse, son, daughter.) If you do not designate anyone, the doctor will be unable to speak to anyone in your family regarding your medical condition.)

Name	Relationship
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Name	Relationship
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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FOR USE OF NON-PARTICIPATING PROVIDERS

I hereby acknowledge & understand that under the terms of my insurance plan should I at any time &for whatever reason utilize the non-emergent services of any non-participating provider (including, but not limited to, doctor, laboratory, radiology & other ancillary services) I may not be covered in whole or in part of the associated costs and will bear the full financial responsibility for the costs of such services.

4) SIGNATURE: _____ Date: _____