

Retina Institute of Virginia, PLLC

In connection with the medical services currently received from Retina Institute of Virginia (the “Practice”), the undersigned hereby agrees as follows:

Authorization to Release Information: I authorize the Practice to release my medical and/or financial information, as may be necessary, to my insurance company(s).

Payment Agreement: I authorize my insurance company to pay any benefits due to me directly to the Practice. I understand that I am ultimately responsible for payment to the Practice for any service rendered to me. I also understand and agree that any sum of money paid under this assignment shall be credited to my account and in the event the sum is insufficient to liquidate my account, I shall be personally liable for the unpaid balance of the account. I understand that reasonable attorney and collection fees can be added to my account if I do not handle payment in a current manner. Returned check charges (\$25.00 per incident) can be added to my account. The parents/guardians will be responsible for services rendered to a minor.

No Insurance Coverage: I understand that I am fully responsible for payment for service(s) provided by the Practice to me and/or my dependents, at the time the service(s) are rendered, unless other financial arrangements have been made with the Practice.

Medicare Signature Authorization: I request that payment of authorized Medicare benefits be made either to me or, on my behalf, to the Practice for any services furnished to me by the Practice. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services.

Financial Interest Disclosure: Drs. Astruc, O’Keefe, and Tabassian have an ownership interest in Stony Point Surgical Center and receive a financial benefit from the facility. Certain federal and state laws require disclosure of a physician’s ownership interest in an ambulatory surgery center.

Print Name

Signature of Responsible Party

Date