Retina Macula Specialists, PLLC

INSURANCE SIGNATURE AUTHORIZATION

I understand that Dr. Jaime Membreno may provide services and/or devices that he deems necessary for my care/treatment which my insurance may not cover. Dr. Jaime Membreno's decision is a professional one made in my best interest and is not dictated by any governing agency. To this end, I hereby authorize and accept fill responsibility for the charges associated with such services and/or devices. I authorize Retina Macula Specialists, PLLC to use this signature as a release to the Social Security Administration, its intermediaries, carriers and/or to the billing agent of this physician or supplier of any information needed for this or a related Medicare/Insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefit either to myself or the party who accepted assignment. I may revoke this authorization by notifying Retina Macula Specialists, PLLC in writing.

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

I hereby authorize the release of any medical records which may be requested by my insurance company for the purpose of processing and insurance claim. A copy of this authorization may be used in lieu of the original. I further authorize release to any subsequent treating physician any medical information and/or records concerning diagnosis and treatment.

PAYMENT SIGNATURE AUTHORIZATION

I hereby authorize payment by my insurance company to Dr. Membreno, directly. I understand that any payment received over and above my indebtedness will be refunded to me when my bill is paid inf full and that I am financially responsible for charges not covered under this authorization. I understand that I am legally responsible for the payment of charges of services. Furthermore, I understand that payment for charges not covered contractually by insurance are due at the time of service. I have read, understand, and agree Retina Macula Specialists, PLLC financial policy. I permit a copy of these authorization and assignments to be used in place of this original.

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Signature of Patient or Legally authorized individual Date

INFORMATION REGARDING DILATING EYE DROPS

Dilating eye drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get better view of the inside of the eye. Dilating drops frequently blur vision for a length which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Adverse reaction, such as acute-closure glaucoma, may be triggered from dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Jaime Membremo, MD and/or such assistants as my be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

PHOTO/VIDEO/AUDIO RECORDING

Unless express permission is giving photo, audio and visual recordings are not permitted during your visit.

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Signature of Patient or Legally authorized individual Date