Diseases and Surgery of the Retina, Vitreous and Macula

Peter Condax MD George Condax MD

Patient Name:_______________________________________ **DOB:**____________

Please read carefully and sign where indicated

Financial Policy: I understand that I am financially responsible for all charges whether or not paid by my insurance and that any co-payments (including co-insurance and deductible) are due at the time of service. I understand that I am responsible for obtaining any referrals from my Primary Care Physician, if required, prior to my visit.

1. Self pay: Payment is expected at the time of service.

Patient/Responsible Party Signature: ___________________________________ Date: ________

2. Assignment of Insurance Payments and Release: I hereby assign directly to Peter Condax MD/George Condax MD, Peter Condax MD PC all insurance benefits otherwise payable to me for services rendered to me or my dependants. I authorize the doctor to release information to insurance carriers concerning my illness, accident, and/or treatments. I authorize the use of this signature on all insurance submissions and permit a copy of this authorization to be used in place of the original.

Patient/Responsible Party Signature: ___________________________________ Date: ________

3. Medicare Patients Authorization: I request that payment of authorized Medicare benefits be made on my behalf to Peter Condax MD/George Condax MD, Peter Condax MD PC for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is in Item 9 of the HCFA-1500 form, or else on other approved claim forms or electronically submitted claims, my signature authorized the release of the information to the insurer or agency shown in Medicare assigned cases, the physician or supplier aggress to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.

Signature of Medicare Beneficiary: ____________________________________ Date: ________

Notice of Privacy Practices & Consent to Release Information: I have been given the opportunity to review the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I may receive a copy of this document by requesting it or by visiting their web site www.RetinaMaculaMD.com

I permit Peter Condax MD/George Condax MD to release any medical information to the physicians involved in my care. The office may call my home or other designated location and leave messages on voice mail or in person in reference to appointment reminders and insurance items. In addition, the practice may mail appointment reminders and patient statements to my address on file.

I give my permission to discuss my medical information with the following family members or other designees listed below.

Name(s) ____

Patient/Responsible Party Signature: __________________________________ Date: ________