Patient Consent, Assignment of Benefits, Financial Agreement

THIS NOTICE DESCRIBES IMPORTANT INFORMATION REGARDING YOUR CONSENT, REIMBURSEMENT OF MEDICAL SERVICES AND YOUR FINANCIAL REPONSIBILITIES. PLEASE REVIEW IT CAREFULLY.

Consent for examination and treatment
I consent to evaluation and treatment by or under the direction of the physicians of Retina Associates, including his/her associates, fellows and assistants. I understand it is necessary for my pupils to be dilated (enlarged) in order for my retina to be examined. Mydriatic (dilating) drops frequently blur vision and make bright light bothersome. It is not possible to predict how my vision will be affected and for how long. I should not drive a vehicle or operate machinery following my appointment. Adverse reaction, such as acute angle closure glaucoma, may be triggered from dilation. This is extremely rare and treatable with immediate medical attention. I consent to pupil dilation at each visit and understand the visual side effects and risks described above. I understand and agree I should make arrangements not to drive myself following my appointments.

Medicare and Primary Insurance
I request that payment of authorized benefits be made on my behalf to Gitter and Cohen, LLC dba Retina Associates for services furnished to me by the healthcare providers of Retina Associates. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and/or any other healthcare insurance plans and their agents responsible for the reimbursement of my healthcare claims 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 my healthcare claims. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or entity. Retina Associates accepts the charge reimbursement determination of the Medicare Carrier and/or my insurance carrier(s) as full reimbursement as provided in their participating provider agreement. I am responsible for copayments, coinsurance, deductible, out-of-pocket expenses and non-covered services as determined by my healthcare plan(s). My signature further verifies that I will notify Retina Associates of any changes to my health insurance coverage status, including benefit and plan changes and if I join an HMO or other plan in which my Medicare or other healthcare benefits have been relinquished. I understand it is my responsibility to update Retina Associates of any changes in my healthcare coverage.

Medigap and Secondary Insurance
I understand that if a Medigap policy or secondary healthcare insurance is indicated, my signature authorizes release of the information to the insurer or entity. I request that payment of authorized secondary insurance benefits be made on my behalf to Gitter and Cohen, LLC dba Retina Associates. The same shall apply to tertiary and quaternary healthcare benefit polices.

This assignment of benefits shall remain in effect unless revoked by me in writing. A copy of this assignment and my signature shall remain on file and is considered as valid as the original.

Healthcare Plan Requirements
Some healthcare plans require the insured to seek medical services from certain healthcare providers or facilities or to obtain a referral, authorization, precertification and/or approval in order to reimburse medical fees and costs. I understand and agree that I have personally reviewed my healthcare plan and understand the coverage restrictions applied to the reimbursement of my medical expenses as determined by my healthcare plan. If I fail to comply with the requirements of my healthcare plan I understand and agree that I am responsible for full payment of all medical services rendered.

Preferred Participating Providers
Retina Associates participates as in-network providers with most insurance plans including AARP, Aetna, Benefit Management, Blue Cross Blue Shield, Cigna, Coventry, FARA, First Health, GEHA, Gilsbar, Humana, Humana 65,

Medicare, Medicaid (Bayou Health), Multiplan, Office of Group Benefits, PPOplus, Private Healthcare/American Lifecare, Tricare and United Healthcare. I understand this is not a complete list and if my healthcare plan is not listed above I will verify participation with the front desk. I understand Retina Associates is NOT participating providers for Tenet Peoples Health or Wellcare plans and as such understand and agree that I am responsible for all fees associated with my care. Payment for services are due when services are rendered and may be made by cash, check, debit card, MasterCard, Visa, Discover and American Express.

Facilities
I understand Retina Associates's physicians maintain medical staff privileges and perform vitreoretinal microsurgery at Touro Infirmary, East Jefferson General Hospital and Louisiana Heart Hospital. Offices are maintained in the Parishes of Orleans, Jefferson, St Tammany, Tangipahoa, Lafourche and Terrebonne.

Non-covered Services and Advanced Beneficiary Notice
I understand that my healthcare insurance plan may not cover all services even though my physician determines the service(s) to be medically necessary. Examples of non-covered services include, but are not limited to, services not specified as being covered by my healthcare plan, treatment or tests not authorized by my healthcare plan or services that are specifically excluded or limited by my healthcare plan. I understand and agree that a Advanced Beneficiary Notice (ABN) will be obtain any time it is expected that my healthcare plan may not cover a service. I understand and agree that if a service, test, treatment or drug is not covered by my healthcare plan I am personally responsible for the fees associated with any and all non-covered services, unreimbursed, under reimbursed and/or denied services.

Financial Agreement
I understand that insurance is a means of reimbursement and not a substitution for payment. Retina Associates will file my healthcare claims on my behalf for medical services rendered. I agree to pay all copayments, coinsurance, deductibles, out-of-pocket expenses and non-covered services as determined by my healthcare insurance plan at the time of service. I understand and agree that I am ultimately responsible for payment of all fees for services rendered regardless of my insurance status. I understand and agree to promptly pay any account balances upon the receipt of a statement from Retina Associate or upon arrival at the office prior to services. Furthermore I understand and agree that my account may be accessed additional fees, including interest charges and late fees for outstanding balances, returned payments, the duplication of medical records, special forms or reports and appointment cancellation and no show fees. If it becomes necessary to send my account for collection, I agree to pay collections expenses including attorney's fees as established by the court in addition to my outstanding account balance and administrative account fees. I understand that it may become necessary to terminate the patient-physician relationship if I fail to meet my financial responsibilities or my financial arrangements become unsatisfactory.

Release of Information
Retina Associates may disclose all or part of my medical record, including financial information, alcohol or drug abuse, psychiatric illness, communicable disease and/or HIV status to any person or entity which is liable or under contract for reimbursement of medical services rendered and any healthcare providers or entities participating in my medical care. Retina Associates may also disclose on an anonymous basis any information concerning my care which is necessary or appropriate for the advancement of medical science, medical education, medical research, collection of statistical data or pursuant to local, state or federal law, statute or regulation.

Additional Information
As a courtesy I agree to silence my cellular telephone and other electronic devices upon arrival for my appointments. If I must make or receive a telephone call I will step outside the office. I understand Retina Associates maintains a smoke free environment and will refrain from the use of all tobacco products while at my appointments. Weapons of any kind are strictly prohibited. My appointment time has been reserved for me and I will notify the office 24 hours in advance if I am unable to keep my appointment. I understand and agree my failure to kept scheduled appointments without properly notifying the office will result in a $55.00 fee to my account and restrictions to future appointment bookings. It is requested that I not arrive more that 15 minutes early for my appointments. Late arrivals will be seen as permitted or rescheduled as needed. I understand that due to the nature of the specialty, emergencies may delay scheduled appointments and occasionally make it necessary to reschedule appointments in order to accommodate emergency surgical care. The physicians and staff understand my time is valuable and will work diligently to minimize the length of my visit and ask for my patience and understanding in advance if delays occur.

A copy of this consent, assignment, authorization and agreement may be used in place of the original. I have the right to obtain a paper copy of this notice, upon request, even if I have agreed to accept this notice alternatively i.e. electronically.