West Coast Retina Medical Group, INC
Authorizations & Acknowledgement

1. **RELEASE OF INFORMATION:** I authorize **West Coast Retina**, my treating physicians and their respective designees, to use and disclose my health information for all purposes necessary for treatment, payment and healthcare operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

2. **ASSIGNMENT OF BENEFITS:** I hereby authorize my insurance benefits to be paid directly to **West Coast Retina**. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

3. **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

4. **FINANCIAL LIABILITY:** I have been provided a copy of **West Coast Retina's** financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to **West Coast Retina** for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

   - My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at **West Coast Retina** and I have not obtained such an authorization or referral, or I have received services in excess of such authorization or referral
   - My health plan determines that the services I receive at **West Coast Retina** are not medically necessary and are not covered by my insurance plan
   - My health plan coverage has lapsed or expired at the time I receive services at **West Coast Retina**
   - I have chosen not to use my health plan coverage

5. **PRIVACY POLICY:** I have been provided a copy of **West Coast Retina's** privacy policies and agree to the specified terms. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by West Coast Retina, my individual rights, how I may exercise these rights, and the West Coast Retina's legal duties with respect to my information.

   I understand that West Coast Retina reserves the right to change the terms of its Notice of Privacy Policies, and to make changes regarding all protected health information resident at, or controlled by, West Coast Retina. If changes to the policy occur, West Coast Retina will provide me a revised Notice of Privacy Practices upon request.

Patient Signature	
Printed Name	
Signature	
Date	
Medicare Number (if applicable)	