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 government agency. To this end, I hereby authorize and accept full 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 FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of any of my medical records which may be requested by my insurance company for the purpose of processing an 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

PAYMENT AGREEMENT AND AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

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 in 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 for 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 authorizations and assignments to be used in place of this original.

____ ____________________
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 a better view of the inside of your eye.
Dilating drops frequently blur vision for a length of time 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 angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

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

____ ____________________
Signature of Patient or Legally authorized Individual Date

____ ____________________
Witness Date