DELAWARE VALLEY RETINA ASSOCIATES

PRIVACY NOTICE

Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our Notice of Privacy Practices in the reception area. You are not required to read it. However, please acknowledge that you have been informed of the policy.

Initial_____

ASSIGNMENT of BENEFITS and FINANCIAL POLICY

I authorize that payment of all insurance benefits to which I am entitled, including Medicare or any private health plan, be assigned to the physicians of Delaware Valley Retina Associates for medical care and services furnished to me.

I authorize Delaware Valley Retina Associates to release any of my medical information to the Centers for Medicare Services needed to determine the benefits payable for related services.

I understand that I am financially responsible for any amount not covered by insurance or deemed the subscriber's responsibility as defined by my insurance company including copays and deductibles. An additional $20 fee will be charged if a copay is not provided at time of service. There is a $35 fee for returned checks. If DVRA does not participate with my insurance, or if I do not have health insurance, I agree to provide full payment at the time of service.

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Patient/Guardian signature Date