LIFETIME INSURANCE ASSIGNMENT AND AUTHORIZATION FORM

Southeastern Retina Specialists, PA (SRS) is pleased to file your insurance on behalf of each patient. In order to correctly process your insurance claims, the patient or responsible party is responsible for providing, at the time of service, the most current address, phone number and insurance information.

I hereby instruct and direct my past and/or present insurance company to issue payment(s) directly to: **Southeastern Retina Specialists, 7740 Point Meadows Drive, Suite 3A, Jacksonville, FL 32256** of benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for all medical, surgical and diagnostic services rendered by SRS. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to SRS and I agree to pay, within ninety (90) days of the date of the first monthly bill, any balance of said charges over and above insurance payment(s), including applicable copayments, deductibles, co-insurances, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to SRS. A photocopy of this assignment shall be as effective and as valid as the original. Furthermore, I understand that SRS accepts Medicare assignment and Medicare payments will be directed to SRS. I authorize SRS to use or disclose information about me to any person or corporation which is or may be liable for all or any portion of the charges incurred in connection with these services, including insurance companies, health care service plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement. I authorize SRS to fax the results of my evaluations to my referring physician, if appropriate.

I further agree and acknowledge that:

- Should I decline to sign this Lifetime Insurance Assignment and Authorization Form, I assume full responsibility for all charges incurred for services provided at SRS and that these charges are due in full at the time of service.

This Lifetime Insurance Assignment and Authorization is ongoing and will not expire until such time as written notice of revocation is provided.

______________________________	______________________________
Signature of Patient or Legal Representative	**Date**

CONSENT FOR MEDICAL INFORMATION RELEASE

There are times we are asked to release your healthcare information to family members or other individuals, including but not limited to, test results, appointment information, diagnoses and treatment plans, and/or billing information. If you would like for us to release your information to any other individual, please list those person(s) below and their relationship to you. Please make notes as necessary.

______________________________	______________________________
Name of Person	**Relationship**
______________________________	______________________________
Name of Person	**Relationship**
______________________________	______________________________
Name of Person	**Relationship**

☐ **NO INFORMATION TO BE RELEASED** (Please INITIAL box)

This consent to release information will remain in effect until revoked in writing.

______________________________	______________________________
Signature of Patient or Legal Representative	**Date**