Retina Center Of Pensacola

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:

SUBSCRIBER'S NAME: **ID/ POLICY#**

GROUP #

GROUP NAME:

SUBSCRIBER DATE OF BIRTH: **SUBSCRIBER'S SS#**

SECONDARY INSURANCE COMPANY NAME:

SUBSCRIBER'S NAME:

ID/ POLICY# **GROUP#**

GROUP NAME:

SUBSCRIBER'S DATE OF BIRTH: **SUBSCRIBER'S SS#**

MY SIGNATURE BELOW CERTIFIES THAT:

- I understand that, ***if necessary***, it is my responsibility to obtain any necessary referral or authorization from my insurance carrier.
- I also understand that my insurance plan may not cover the entire bill and that I will be financially responsible for any coinsurance, deductible, and non-covered service as determined by the insurance carrier.
- I understand that ***if I do not have health insurance*** to cover this bill I will be financially responsible for any and all charges incurred.

AUTHORIZATION TO FILE INSURANCE: I hereby authorize AREF RIFAI, M.D., to release to Medicare or other insurance carrier or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. This authorization includes release of information concerning HIV testing, diagnosis or treatment of AIDS, AIDS related conditions, drug or alcohol abuse, drug related conditions, and/or psychiatric/psychological diagnosis/treatment. Also, I authorize and request Medicare or any other insurance carrier to pay directly to the above named physician the amount due to me in my pending claim for medical or surgical services.

SIGNATURE: _____DATE:_____