

**COLUMBIA OPHTHALMOLOGY CONSULTANTS**

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|---|--|--|---|
| <input type="checkbox"/> Lama Al-Aswad, MD      | <input type="checkbox"/> Stanley Chang, MD     | <input type="checkbox"/> Thomas Flynn, MD    | <input type="checkbox"/> Amelia Schrier, MD |
| <input type="checkbox"/> James D. Auran, MD     | <input type="checkbox"/> Michael Chiang, MD    | <input type="checkbox"/> Scott Smith, MD     | <input type="checkbox"/> R.T. Smith, MD     |
| <input type="checkbox"/> Gaetano Barile, MD     | <input type="checkbox"/> Lucian Del Priore, MD | <input type="checkbox"/> Reza Iranmanesh, MD | <input type="checkbox"/> Stephen Trokel, MD |
| <input type="checkbox"/> Richard Braunstein, MD | <input type="checkbox"/> Linsy Farris, MD      | <input type="checkbox"/> Leejee Suh, MD      | <input type="checkbox"/> Howard Fine, MD    |
| <input type="checkbox"/> Daniel Casper, MD      | <input type="checkbox"/> John Flynn, MD        | <input type="checkbox"/> William Schiff, MD  | <input type="checkbox"/> Stephen Tsang, MD  |

Name of Beneficiary: \_\_\_\_\_

Health Insurance Claim Number (HICN): \_\_\_\_\_

I request that payment of authorized health insurance benefits, including Medicare and Medigap, be made either to me or on my behalf to Dr. \_\_\_\_\_ for services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits payable for related services.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**Commercial Insurance**

I hereby authorize direct payment of surgical / medical benefits to Dr. \_\_\_\_\_ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance, including co-pays, deductibles, refractions, and differences between surgeon's charges and allowables. I hereby authorize Dr. \_\_\_\_\_ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**Advance notice regarding insurance reimbursement and beneficiary agreement**

I have been informed that refraction (the measurement of one's eyeglass prescription, and the determination of the best visual sharpness) is usually not considered by insurance companies, health maintenance organizations, and Medicare to be medically reasonable of necessary. Knowing this, I have instructed the doctor to proceed with the services. If insurance decides to reduce or even deny the fee or services, I agree to pay the doctor's fee in full.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_