RETINA CONSULTANTS

MARTIN URAM, M.D., M.P.H.
RUPAN TRIKHA, M.D.

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE/MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO MARTIN URAM, M.D. FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN OR SUPPLIER. I GIVE AUTHORIZATION TO ANY HOLDER OF MEDICAL INFORMATION CONCERNING ME TO RELEASE INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS.

INSURANCE/MEDICARE WILL ONLY PAY FOR SERVICES THAT IT CONSIDERS TO BE MEDICALLY “REASONABLE AND NECESSARY”. IF INSURANCE/MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH OTHERWISE COVERED, IS NOT “REASONABLE AND NECESSARY” UNDER ITS STANDARDS IT WILL DENY PAYMENT FOR THAT SERVICE.
I WISH TO HAVE SERVICES PROVIDED BY MARTIN URAM, M.D. or RUPAN TRIKHA. M.D., THEREFORE I AGREE THAT, IF INSURANCE/MEDICARE DENIES PAYMENT FOR THESE SERVICES I SHALL REMAIN PERSONALLY RESPONSIBLE FOR ANY BALANCE DUE.

I UNDERSTAND THAT MY PUPILS WILL BE DILATED AND MY VISION WILL BE BLURRY AFTERWARDS, THEREFORE I MAY BE UNABLE TO DRIVE.

I UNDERSTAND THAT IF MEDICALLY NECESSARY FOR A DIAGNOSIS, TESTING SUCH AS FLUORESCEIN ANGIOGRAMS, ULTRASOUND, VISUAL FIELD EVALUATION, AND OTHER OPTIC NERVE AND RETINAL EVALUATIONS MAY BE PERFORMED WITH MY INFORMED CONSENT.

AFTER MY DOCTOR REVIEWS THE RISKS AND BENEFITS OF ANY NECESSARY PROCEDURES WITH ME DURING MY CONSULTATION, I GIVE PERMISSION FOR OPHTHALMIC LASER TREATMENTS, CRYOTHERAPY, INTRAVENOUS INJECTION OF DYES AND MEDICATIONS AND/OR INTRAOCULAR INJECTION OF MEDICATIONS AND GASES.

I UNDERSTAND THAT A FACILITY FEE FOR THE **RETINA CONSULTANTS SURGERY CENTER** WILL BE CHARGED TO MY INSURANCE IF I UNDERGO LASER EYE SURGERY.

I AM AWARE THAT I AM RESPONSIBLE FOR ANY OUTSTANDING BALANCE NOT PAID BY MY INSURANCE COMPANY

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I WAS OFFERED THE **NOTICE OF PRIVACY PRACTICES** FOR THE PRACTICE OF MARTIN URAM, M.D., P.A. RETINA CONSULTANTS TO READ , AND IF I CHOOSE, TO KEEP AND TAKE WITH ME.

PRINT NAME: ____________________________ SIGNATURE: _________________________________

DATE: ________________________________