Kevin J. Blinder, MD
Sabin Dang, MD
Alia K. Durrani, MD
Nicholas E. Engelbrecht, MD
Avinash V. Honasoge, MD, PhD

THE RETINA INSTITUTE

Daniel P. Joseph, MD, PhD
Thomas K. Krummenacher, MD
Athanasios Papakostas, MD
Gaurav K. Shah, MD
Bradley T. Smith, MD

Administrative Office: 2201 S. BRENTWOOD BLVD. / ST. LOUIS, MISSOURI 63144 / 314.367.1181 or 800.888.0011 / fax: 314.968.3375 / TRI-STL.com

Assignment of Benefits

Patient's Name: _____ Date of Birth: _____

Insurance Name: _____

Member ID#: _____ Group #: _____

Guarantor Name: _____ Date of Birth: _____
(If other than patient)

Secondary Insurance Name: _____

Member ID#: _____ Group #: _____

Guarantor Name: _____ Date of Birth: _____
(If other than patient)

Please read carefully, sign on the signature line, and return to the receptionist when completed.

Authorization to Release Information
I hereby authorize The Retina Institute to release information necessary for the processing of my medical claim.

Authorization to Assign Benefits/Medicare Authorization "Signature on File"
I hereby assign transfer all title and rights and interests for services rendered to The Retina Institute.

I hereby authorize the insurance company(s) to make payment directly to The Retina Institute for medical benefits otherwise payable to me. I hereby acknowledge that I am the subscriber, guarantor, and/or responsible party and therefore accept legal financial responsibility for all charges incurred. I agree to forward all insurance reimbursements directly to The Retina Institute upon receipt from my insurance carrier up to and including the full amount of the fees charged. In the event of non-payment, I acknowledge I will be responsible for any balances due including collection and legal fees associated with the collection of said balance. A fee of 25% of the total balance due will be added to my account should it be turned over to an outside agency. I have read these terms and hereby assume responsibility for paying any charges according to these terms. For more information regarding our Payment Policy, visit our website at www.tri-stl.com/forms

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

I understand that if I do not provide the correct insurance information, I will be responsible for all charges incurred.

I understand that any overpayment will be refunded to me.

Copays:
You are expected to pay your copay at the time of service. After claim submission and insurance payment, you will be responsible for any deductible, coinsurance, or other out of pocket expenses.

I attest the insurance information given above is accurate and correct.

Signature: _____ Date: _____

For more information, please visit our website at www.tri-stl.com/patient-faq