Retinal Consultants of So. CA Medical Group

SHOULD ANY OF MY INSURANCE INFORMATION BE INCORRECT OR INVALID I WILL ASSUME RESPONSIBILITY IN FULL FOR ANY AND ALL CHARGES INCURRED.

I AUTHORIZE AND REQUEST THAT PAYMENTS UNDER MY MEDICAL INSURANCE PROGRAM BE MADE DIRECTLY TO DR. DIDDIE, RETINAL CONSULTANTS OF SO. CA, FOR ANY SERVICE FURNISHED TO ME. I ALSO AUTHORIZE DR. DIDDIE TO RELEASE ANY INFORMATION NEEDED FOR PAYMENT OF CLAIMS. I FURTHER PERMIT COPIES OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

*I UNDERSTAND THAT MY EYES WILL BE DILATED AT EACH EXAM AND THAT SINCE DILATING DROPS CAN CREATE A VISUAL DISTURBANCE, THE ASSISTANCE OF SOMEONE ELSE FOR TRANSPORTATION IS RECOMMENDED. VISION WILL BE MORE BLURRED AFTER LASER TREATMENTS AND OTHER PROCEDURES.

X____
PATIENT OR RESPONSIBLE PARTY

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DATE

PLEASE RETURN THESE FORMS TO THE RECEPTIONIST WITH YOUR INSURANCE CARDS.