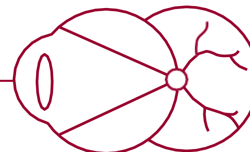
**RETINA & VITREOUS CONSULTANTS OF WISCONSIN LTD.**

MEDICAL AND SURGICAL TREATMENT OF THE RETINA AND VITREOUS



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## AUTHORIZATION TO NOT BILL HEALTH INSURANCE

I, ____________________________________________ (patient name), date of birth _____/_____/_____, have requested that no claim for benefits under my health insurance policy be submitted for assignment and payment to Retina & Vitreous Consultants of WI, Ltd, for date of service _____/_____/_____.

I understand that I am responsible for all charges for services rendered by Retina & Vitreous Consultants of WI, Ltd., for this date of service. ______ Patient Initials

I understand that all charges for this date of service shall be paid in full on the date the services are rendered. ______ Patient Initials

I understand that I am not entitled to a discount of the professional fees for any service rendered on this date by Retina & Vitreous Consultants of WI, Ltd. ______ Patient Initials

I understand that no claim shall be submitted to my insurance carrier for this date of service in order to satisfy my deductible. ______ Patient Initials

I understand that I have the right to revoke my right to not have any claims submitted after this appointment. ______ Patient Initials

I understand that my insurance carrier may elect to deny me benefits for any condition(s) that may arise due to lack of documentation from services rendered by Retina & Vitreous Consultants of WI, Ltd., that I have/had received but elected not to utilize my insurance benefits for. ______ Patient Initials

________________________________________ ________________________________________
Patient's signature Witness signature

________________________________________ ________________________________________
Patient Name Date

____________________________
Account Number

*F:/Mngmt/Common/HIPAA Forms/Authorization To Not Bill Health Insurance08-2019*