2101 Medical Park Drive
Suite 303
Silver Spring, MD 20902

Lifetime Authorization for Insurance / Medicare / Medicaid

I request that payment of authorized insurance / Medicare / Medicaid benefits be made on my behalf for services furnished me by DC Retina / Neal Adams MD PC.

I authorize any holder of medical or other information about me to release the health care financing administration and/or it's agents information needed to determine these benefits for related services.

I request that payment of authorized insurance / Medicare / Medicaid benefits be made on my behalf to DC Retina / Neal Adams MD PC for any services for me by a physician or supplier. I authorize any holder of medical information about me to release any of my insurance companies any information needed to determine these benefits payable for related services.

I hereby authorize payment directly to DC Retina / Neal Adams MD PC of benefits otherwise payable to me. I understand and agree that any unpaid balances not covered by my medical policy will be payable by me. This includes coverage denies as a result of preexisting conditions.

I permit a copy of this authorization to be used in place of the original.

Regulations pertaining to Medicare / Medicaid assignment of benefits apply.

I further authorize DC Retina / Neal Adams MD PC to fax the results of my evaluations to my referring physician(s) if appropriate.

Patient Name: _____

Signature: _____

Name of Person (if other than patient): _____

Relationship to Patient (if other than self): _____

Date: _____