**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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 there shall be no discount of the professional fees for any service rendered on this date by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_., unless approved by the physician in advance. \_\_\_\_\_\_ 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 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