# WELCOME TO OUR OFFICE

Name _____ DOB _____ / _____ / _____

Date of Visit : _____ / _____ / _____

Please read carefully and sign the following agreement.

For our patients with Insurance:

I authorize the release of any medical or other information necessary to process my claim to the insurance carrier. I understand that it is my responsibility to know my insurance coverage and to obtain any referrals or authorizations necessary. I also understand that any balance not paid by the insurance company after 60 days is my responsibility. I authorize the payment of medical benefits to Dr. Gene Terrezza by my insurance carrier.

Lifetime signature: _____

Relationship to Patient: _____ Print Name: _____

For our patients with Medicare:

Medicare will only pay for services that it determines to be " reasonable and necessary"under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. If there is no medical reason for your visit, or no medical diagnosis then Medicare will likely deny your claim. If Medicare denies payment, I agree to be personally and fully responsible for payment. I authorize the release of any medical or other information necessary to process my claim to the insurance carrier. I understand that it is my responsibility to know my insurance coverage and to obtain any referrals or authorizations necessary. I also understand that any balance not paid by the insurance company after 60 days is my responsibility. I authorize the payment of medical benefits to Dr. Gene Terrezza by my insurance carrier.

Lifetime signature: _____

Relationship to Patient: _____ Print Name: _____

I have received a copy of Privacy Practices from

Dr. Gene Terrezza, O.D., & Associates, P.A.

Patients Initials _____