

RAANANAH S. KATZ, M.D., F.A.C.S.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges incurred, by me or my dependent. I am also responsible for obtaining any prior authorization needed for medical services. If authorization (i.e. referral and/or authorization number) have not been obtained prior to medical services. I will be financially responsible for any charges incurred at the time of services rendered.

SIGNATURE _____ DATE _____

MEDICARE PART B CERTIFICATION FOR PAYMENT (ONLY APPLIES TO PATIENTS ON MEDICARE)

I certify that the information given by me is applying for payment under title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration for its intermediaries or carrier any information needed for this or a related Medicare claim. I request that the payment of any authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorized such physician to submit a claim to Medicare for payment to me.

SIGNATURE _____ DATE _____

REFRACTION CONSENT (ONLY APPLIES TO MEDICARE PATIENTS)

Medicare does not pay for all services. The Refraction is a service that is not covered by Medicare or by you co-insurance. Medicare requires that you understand that you will be financially responsible for this charge.

A Refraction is a test that will determine if there has been any changes in your glasses prescription. This test is necessary for the doctor to determine if you may or may not need an updated glasses prescription. A Refraction may also be needed for the doctor to detect any vision loss due to an injury of the eye.

I understand that my insurance will **NOT** pay for this service. I also understand that I am financially responsible.

_____ I Choose to be refracted

_____ I Choose **NOT** to be refracted

SIGNATURE _____ DATE _____