



Dear Patient,

We ask that you please read and sign this form as it concerns you, the patient.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy, therefore we urge you, the patient to please check with your insurance company regarding your coverage. It is YOUR responsibility to know YOUR individual coverage and its limitations. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company.

If you need a referral from your insurance company or from your primary care physician or from another doctor to be seen in this office, the referral must be present at the time of your visit. If it is not available, it will be your responsibility to obtain one. Consequently, you will need to reschedule your visit should a referral not be available. We welcome you to call your physician and have your referral faxed to us.

If you have a co-payment or out-of-pocket expenses, deductible, etc, it must be paid at the time of service.

Please call your insurance company and learn about your coverage. It may save you a lot of confusion and out of pocket expense.

The second issue you are signing for is: that you

By signing below, you are also indicating that you have received and read our Fort Lauderdale Retina Institute Notice of Privacy Practices.

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Signature

Date