Insurance Payment Disclosure & Signature

I authorize Richard S. Casden, M.D., Betty Klein, M.D., and Hindola Konrad, M.D. to receive all insurance payments from my current medical insurance plan.

I agree to pay applicable co-payments, deductibles and non-covered fees. I will pay my deductible and non-covered services upon first notification.

I agree to pay applicable co- payments at the time of service.

If my plan requires a prior approval or referral, I accept responsibility for all payments for non-approved and/or non-referred charges.

I agree to release all information necessary for my current insurance plan to process my claims.

I agree to pay in full at the time of service if I do not have insurance or choose not to have my insurance filed by your office.

"I hereby acknowledge that I have received a copy of Acuity Eye Care's "Notice of Privacy Practice." I understand that if I have any questions or complaints regarding my privacy rights that I may contact Suzanne Grazioli, Privacy Officer for Acuity Eye Care, at (203)794-0117. I further understand that the practice will offer me updates to this notice should the notice change in any way.

I understand and agree with the above authorization and statements.

X _____ _____

Print Name of Patient or Representative / Parent or Guardian of Minor Child (If not the insured) Date

X _____ _____

Signature of Patient or Representative / Parent or Guardian or Minor Child Date

[ ] Patient refused to sign

[ ] Patient unable to sign Reason: _____

_____