ESTERMAN EYE INSTITUTE
Bradley J. Esterman, M.D.
1674 S. Federal Highway
Delray Beach, FL 33483
(561) 279-7799

At ESTERMAN EYE INSITUTE, it is our goal to provide the highest level of professional medical service to our patients. Please feel free to ask our staff if you have any questions pertaining to the following:

Financial Agreement
As a courtesy to our patients, we will submit claims to Medicare & Medicaid for you. However, this does not relieve your financial responsibility for deductible and coinsurance amounts. Claims denied by your insurance carrier due to any reason will be your financial responsibility.
Medicare does NOT pay for all of your health care costs. Medicare only pays for covered benefits. Medicare will NOT pay for: 1) routine eye care, eyeglasses or examinations. 2) Refraction to the eyes for measurement of lenses for glasses (prescription for glasses)

Assignment of Benefits

I hereby authorize my insurance carrier to make payments directly to ESTERMAN EYE INSTITUTE on my behalf.

Patient's Rights of Disclosures
In general, the HIPPA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information be made by alternative means. We are dedicated to maintaining the privacy of your personal information.

I understand at this time the office is not part of any HMO. It is my full responsibility to pay for the office visit at this time of service.

Please sign the following so we may obtain any eye record, if needed, from other eye physicians.

You are hereby authorized to provide:

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With any eye records for examination (including visual field test and eye photographs, which may be requested regarding the eye condition or treatment) rendered to________________________________ (your name).

Pupil Dilation
I understand that during my exam my doctor may dilate my eyes in order to diagnose and evaluate important eye conditions. If I am dilated, my vision may become blurry and it is not advisable to drive for at least 2 hours or until my vision becomes clear again. I will be advised if my doctor feels that it is necessary to undergo dilation of the pupils and I have the right to refuse, however, I understand that refusal of the recommended procedure may have risks in missed diagnoses or treatments.

I AGREE THAT ALL THE INFORMATION GIVEN IS ACCURATE AND THAT I HAVE READ ALL INFORMATION INCLUDED IN THIS NEW PATIENT PACKET.

SIGNED____ Date________________