Harold I. Rodman, M.D.
Joel M. Engelstein, M.D.
8630 Fenton Street, Suite 130
Silver Spring, MD 20910

_____ _____
Subscriber Name Insurance Identification Number

"I request that payment of authorized_____(insurance co.)_____benefits be made on my behalf to Harold I. Rodman, M.D. or Joel M. Engelstein, M.D. for any services furnished by that physician. I authorize any holder of my medical information about me to be released to the previously stated insurance company and its agents if information is needed to determine these benefits or the benefits payable for related services."

x_____ _____
Signature Date

PHYSICIAN NOTICE

Your insurance company will only pay for services that are covered under your specific contract. Some insurance companies do not pay for:

ROUTINE EXAMS, REFRACTIONS, OR PACHYMETRY

It is your responsibility to know what services are covered under your insurance plan.

BENEFICIARY AGREEMENT

I agree to be personally and fully responsible for payment should my insurance not cover any of the services provided to me.

x_____ _____
Signature Date