Eyecare Physicians & Surgeons, LLC

____ Initial **Consent for Medical Treatment**

I voluntarily consent to medical treatment and diagnostic procedures provided by Eyecare Physicians and Surgeons, LLC. I acknowledge that no guarantees have been made as to the result of treatments or examinations.

____ Initial **Authorization for Release of Information and Assignment of Insurance Benefits**

Eyecare Physicians and Surgeons, LLC is authorized to release any medical information required in the processing of my applications, submission of information for financial coverage, or other information about me to government regulatory agencies (federal or state) as required by law. For Medicare/Medicaid beneficiaries – I have provided all necessary information for proper assignment of Medicare/Medicaid benefits.

____ Initial **Agreement of Financial Responsibility**

Payment is made in full at the time of service including, but not limited to, all copays and deductibles. I guarantee payment of all charges associated with services received. It is my responsibility to verify participation status of the physicians with my health plan prior to the patient visit and obtain prior authorizations as required by my health plan prior to my visit.

____ Initial **Agreement of Financial Responsibility for Non-Covered Services**

By signing and dating this form, I am indicating that I have been informed that the services I receive today may not be covered. I ***may*** be responsible for any amounts not covered, for any reason; most common are indicated below:

- Rendering physician is not a contracted/credentialed provider for your health plan.
- My insurance/primary care physician has not provided a referral/authorization for service.
- My condition may be considered pre-existing based on length of coverage with insurance plan.
- Your service may not be considered medically necessary by your insurance plan.

H.I.P.A.A. (Health Insurance Portability and Accountability Act) Notification:

I acknowledge my receipt of a copy of the Notice of Privacy Practice.

I understand that the consent for medical treatment, authorization for release of information, assignment of insurance benefits and agreement of financial responsibility can only be revoked upon written notice. By signing below, I acknowledge that this consent form has been read in full and explained, as necessary.

_______________________________________   ___________________________________

Signature of Patient (Parent or Legal Guardian)   Date and Time

*****Please list any family members or others who may be involved in coordinating your care or payment for care. (If you wish no one to have access to this information, please write "none")***

Name	Relationship	Type of Information
______________________________	___________	____All ___Other (specify)___________
______________________________	___________	____All ___Other (specify)___________

Can message be left on your home or cell phone ____Yes ____No

Can message be left on your work phone ____Yes ____No

NOTICE: Patients cannot be seen until this form is filled out completely.