PATIENT CONSENT AND AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatments, administration of dilating eye drops, anesthetics and performance of diagnostic and/or surgical procedures.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician (s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician (s) by the insured or his/her family.

RELEASE OF INFORMATION: The physician (s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician (s) or to the patient or to a family member or employer of the patient for all or part of the physician (s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

H.M.O DISCLAIMER: I certify that I AM OR I AM NOT presently enrolled in any Health Maintenance organization (H.M.O). Subsequent rejection of a claim as a result of this admission, due to current enrollment in a H.M.O Plan will constitute responsibility for payment of claim on my part.

COLLECTION POLICY: I agree that should this account be referred to an agency or attorney for collection that I will be responsible for all collection costs, attorney fees and court costs.

LIFETIME AUTHORIZATION

MEDICARE AND MEDICAID PATIENT CERTIFICATION- PATIENT CERTIFICATION AUTHORIZATION TO REALEASE INFORMATION AND PAYMENT REQUESTS: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician (s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Date

Witness

Print Patient's Name

Patient's Signature/Person Responsible

Patient unable to sign due to: