PROFESSIONAL EYE CARE ASSOCIATES, INC.
PATIENT CONSENT AND FINANCIAL AGREEMENT

Patient Name: _____ D.O.B._____
PLEASE PRINT

1. CONSENT TO ROUTINE AND MEDICAL EYE CARE AND TREATMENT

I request and authorize the doctors and employees of Professional Eye Care Associates, Inc. to furnish routine vision care and/or medical eye care and related procedures that are in the best interest of my vision and/or the eye health.

_____ (Patient, parent or guardian, please initial here)

2. HIPAA, PRIVACY PRACTICES INCLUDING RELEASE OF MEDICAL RECORDS INFORMATION

We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices. This notice includes information on how we may use information (records) regarding our treatment of your health conditions and related billing procedures. I acknowledge that Professional Eye Care Associates Inc. has provided or made its privacy notice available to me.

_____ (Patient, parent or guardian, please initial here)

3. PAYMENT GUARANTEE AND ASSIGNMENT OF BENEFITS

- **All co-pays (both medical and/or vision) are due at the time services are rendered.**
- **Payment in full is due prior to ordering any material.**
- **All balances must be paid in full prior to receiving any material.**

For services and products rendered by Professional Eye Care Associates, Inc. I guarantee payment of the account and agree to pay such account at the time services are rendered, if it will not be paid by my insurance carrier. I understand that the Payer may require authorization prior to my receiving treatment and that it is my responsibility to obtain that prior authorization and know the coverage of my plan. I understand that receiving prior authorization does not guarantee that my payer will pay it, because the benefits permitted depend upon my individual healthcare plan. I further understand that any out-of-pocket charges, co-payments, co-insurance, and deductibles will be my responsibility. If the amounts due to Professional Eye Care Associates, Inc. for services rendered become delinquent and the debt is referred to an attorney and or collection service, I understand and agree that Professional Eye Care Associates, Inc. may recover from me all cost and expenses incurred in the collections efforts, including any interest due. I acknowledge that if my child/dependent is cared for by Professional Eye Care Associates, Inc. that I will be responsible for payment for services provided under these same terms and conditions. To the extent there is third party coverage of payment and services, I assign to Professional Eye Care Associates, Inc. all related benefits by payer on my behalf. I understand and agree that I may be required to pay a late fee if I do not pay in full on the date services are rendered. I acknowledge that Professional Eye Care Associates Inc. has made their Patient Financial Policy available to me.

_____ (Patient, parent or guardian, please initial here)

4. MEDICARE AGREEMENT (if applicable)

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by Professional Eye Care Associates, Inc. (or the party who accepts assignment), including services provided by the doctor. I authorize the release of any medical information about me to the Health Care Financing Administration and its agents, as well as any additional information needed to determine my benefits for related services.

_____ (Patient, parent or guardian, please initial here)

I have read all of the above and consent to it. I understand I may revoke this consent at any time but in doing so, or in refusing to sign, that I must pay for my services in full prior to treatment as my payer cannot be billed on my behalf without this signed consent.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

SIGNATURE OF WITNESS OR EMPLOYEE INITIALS **DATE**