



**PATIENT AUTHORIZATIONS/CONSENTS**

I consent to the treatment necessary for the care of \_\_\_\_\_  
Patient Name

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable, and that a copy of this authorization can be used in place of the original. I allow fax transmittal of my medical records, if necessary.

I understand that my insurance is a contract between my insurance company and myself and Eye Associates assumes no responsibility for unpaid claims. I authorize claims to be billed electronically.

I acknowledge financial responsibility for services rendered by Eye Associates, including deductibles, co-pays, non-covered services, coinsurance and items rejected or considered "not medically necessary." I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

I understand that there is a \$10 Return Check Fee. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and assign insurance payments to be made directly to Eye Associates.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date \_\_\_\_\_ Signature \_\_\_\_\_

For follow-up visits:

I have reviewed the information I previously provided to make certain it is current and accurate and have made any necessary changes/corrections.

Date \_\_\_\_\_ Signature \_\_\_\_\_

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