Simmons Eyecare Clinic, P.A.

Authorization for Treatment

I hereby authorize and consent to all examination and treatment necessary for the care of the patient named below and consent to any and all procedures incident to such treatment which are deemed necessary by the optometrists of Simmons Eyecare Clinic, P.A. including, but not limited to refraction, dilation, visual field screening, ophthalmic imaging, external photography, and pachymetry. I authorize the release of all medical records by mail or fax transmittal to my referring and/or primary care physicians as well as my insurance company, if applicable.

Assignment of Insurance Benefits

I understand that Simmons Eyecare Clinic will file my **primary** insurance only for office charges with those companies for which they participate. I understand that I am responsible for filing my secondary insurance or any other insurance for balances that my primary insurance doesn't cover. I authorize and request that insurance payments be made directly to Simmons Eyecare Clinic. I understand that certain procedures deemed necessary by the optometrists of Simmons Eyecare Clinic may not be covered by my insurance, and that in such instances I am responsible for all remaining charges. If Simmons Eyecare Clinic does not participate with my insurance company, I understand that I am responsible for all charges in full at the time services are rendered.

Financial Responsibility

I understand and agree that payment is expected at the time serves are rendered. If I have insurance, I agree to pay any applicable co-payments, deductibles, or other non-covered services as required by my insurance company. I understand that failure to pay co-payments, deductibles, or other non-covered services may be viewed by my insurance company as fraud if reported. I will receive a statement for any unpaid balance and understand that payment is due 14 days for the statement date. I understand that failure to pay the balance in full by the due date or make payment arrangements may interfere with my ability to schedule non-emergent appointments as well as increase my risk for formal collections proceedings or small claims proceedings.

Disclosure of Information Review

I understand that my medical records and billing information are the property of Simmons Eyecare Clinic, P.A. and are accessible to Simmons Eyecare Clinic optometrists and staff. The optometrists and staff may use and disclose medical information about me to carry out treatment, payment, and health care operations. I understand that Simmons Eyecare Clinic may share my medical information with a person who is involved in my medical care or payment for my medical care such as my spouse, mother, father, parent or legal guardian. I understand under the HIPAA law that Simmons Eyecare Clinic is required to use and disclose my medical information if I have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition such as HIV or tuberculosis. I also understand that as part of health care operations, Simmons Eyecare Clinic may use or disclose when reminded via telephone or telephone answering service of appointments, benefits or other services. I understand that I have the right to request that Simmons Eyecare Clinic restricts uses and disclosures of my medical information for treatment, payment and healthcare operations. However, I understand that those requests must be in writing and that Simmons Eyecare Clinic is not obligated to agree with the requested restriction.

Acknowlegement of Privacy Practices

A copy of the Notice of Privacy Practices, which includes a complete description of how my medical information will be used, is available from Simmons Eyecare Clinic.

_____

Patient's Name

_____ _____

Release Any Medical Information To ***Relationship***

_____ _____ _____

Patient's or Responsible Person's Signature ***Relationship*** ***Date Signed***