EYE CARE & SURGERY, P.C.

PATIENT'S CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

- I hereby authorize Eye Care & Surgery, P.C., to obtain/release information needed to process insurance claims, and/or to gather pertinent medical documents to ensure my safety. I authorize Eye Care & Surgery, P.C. to bill and to collect from my insurance companies. I hereby authorize the physicians and staff of Eye Care & Surgery, P.C. to perform and do hereby consent to such medical care as they feel is necessary, including diagnostic procedures, medical examinations, and treatments as may, in their opinion, be medically necessary. **I understand that I am ultimately responsible for all outstanding financial balances as well as collection fees generated from the pursuit of payment for such treatment delivered.**

- I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any procedure, treatment, or examination.

- I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Eye Care & Surgery, P.C., for any services furnished me by the physician and staff. I authorize any holder of medical information about me to release to any necessary entities and their agents, any information needed to determine these benefits or the benefits payable for related services.

- I agree that, in order for Eye Care & Surgery, P.C., to service my account or to collect any accounts I may owe, they may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. They may also contact me by sending text messages or e-mails, using any any e-mail address I have provided them to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

CO-PAYS ARE DUE AT THE TIME SERVICES ARE RENDERED. We accept cash, checks, MasterCard, Discover, or Visa.

WE CANNOT GUARANTEE PAYMENT FROM YOUR INSURANCE COMPANY. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED. If your insurance is an **HMO** or managed care that needs a referral, **YOU ARE RESPONSIBLE FOR OBTAINING A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN.** Your referral must be in our office at the time of the visit.

I CONSENT TO THE ABOVE MENTIONED ITEMS.

_____ Date _____

Signature of Patient or Parent/Guardian (if patient is a minor)