



CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care by the physicians and supervised staff of the VRF Eye Specialty Group.

RELEASE OF INFORMATION:

I grant consent to VRF Eye Specialty Group to use and disclose my protected health information for the purposes of treatment, payment, and health care operations. My signature below indicates that I have been provided the VRF Eye Specialty Group's Notice of Privacy Practices. It describes my rights and the duties of the VRF Eye Specialty Group with respect to my protected health information, and provides more detailed information about how they may use and disclose my protected health information. I understand that I have the right to request a restriction as to how my protected health information may be used, but that the VRF Eye Specialty Group is not required to agree to the restriction. I understand I have the right to revoke this consent, in writing, at any time, except to the extent that the VRF Eye Specialty Group has already taken action in reliance on the consent. The VRF Eye Specialty Group reserves the right to change the Notice of Privacy Practices, and I understand that I may request and obtain a copy of the revised notice.

I understand that the physicians and staff of the VRF Eye Specialty Group may discuss my health information with my family or friends unless I expressly restrict that authorization by indicating below. This authorization may be revoked at any time by me in writing.

Do not disclose my protected health information to the following: _____

ASSIGNMENT OF BENEFITS:

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to VRF Eye Specialty Group for any services furnished to me. I authorize any holder of my medical information to release information needed to determine these benefits to CMS (Centers for Medicare and Medicaid Services), its agents, or any insurance carrier I may have. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

FINANCIAL AGREEMENT:

I agree that I am responsible for payment for services provided by VRF Eye Specialty Group. If uninsured, payment is required on the day of service. If insured, I understand that claims will be filed with my insurance company, and that I am responsible for any co-payments, co-insurance, and/or deductibles as designated by my health plan. I understand that the authorized co-payment of my health plan is to be paid on the date of service. I understand that it is my responsibility to inform the VRF Eye Specialty Group of any changes in my personal information or insurance information, and that it is my responsibility to obtain appropriate referrals if required by my insurance company. If my account is sent to an attorney or collection agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.

X _____
Signature, Patient or Legal Representative

Date _____

Print Patient's Name

Witness

If Signed by Legal Representative, Print Name & Relationship