Patient Consent Form

THE CENTER FOR
GLAUCOMA &
CATARACT CARE

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Effective: September 09/01/2023

Consent to Medical Treatment / Authorization to Release Information

I (for) undersigned patient do hereby voluntarily consent to such physician care involving routine diagnostic procedures and medical treatment by, his/her assistants or designees. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this visit. I further authorize The Center for Glaucoma & Cataract Care to release to the insurers herein specified, or to any agency concerned with the payment of the patient's medical charges, any and all information (including copies of records) relating to the patient's care.

Medicare Patients Certification (Medicare Only)

I certify that the information given by me for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Responsibility of Non-Covered Services

I have been informed that the medical procedures, treatments, and services provided to the patient are furnished only at my direction or at the direction of my physician and that there is no representation concerning the medical necessity or reasonableness of such procedures, treatments, or services. The decision as to the necessity or reasonableness of any procedure, treatment, or services is made by the appropriate state medical program, insurance company, or its health insurance agent. I understand that I am responsible for payment for any procedures, treatment, or services, which are provided to me at my request, and which may be determined not to be medically necessary as required by the appropriate government, or insurance medical program.

Assignment of Insurance Benefits / Distribution of Overpayment / Obligation or Guarantor

I hereby authorizes all my insurers, whether or not specified, to make payments of insurance benefits directly to The Center for Glaucoma & Cataract Care, but such payments shall not exceed this doctor's regular charges. I recognize, however, that I remain financially responsible to The Center for Glaucoma & Cataract Care for charges not paid or covered by said insurers. I also hereby authorize any overpayment to The Center for Glaucoma & Cataract Care regarding this visit which would otherwise be payable to me to be applied and credited against any balance due to The Center for Glaucoma & Cataract Care for which I am the responsible party.

Responsibility of Patient

I hereby guarantee full and prompt payment to The Center for Glaucoma & Cataract Care of all charges made as a result of services rendered during this visit. I further agree that, if permissible by law, I will be responsible for any legal or court cost required in the collection of any unpaid accounts. If you are unavailable to make your scheduled appointment, please provide the office with 24 hour's notice; if not done so you are subject to a no call/ no show fee.

Accidental Exposure of the Healthcare Worker

I understand that, as permissible by law, if any healthcare worker is exposed to the patient's blood or other bodily fluid, that the office may perform test(s) on the patient's blood or other bodily fluid to determine the presence of human immunodeficiency virus (HIV, the virus associated with AIDS). I consent to the testing for other communicable diseases, including but not limited to hepatitis and syphilis, in the event of an accidental exposure to a healthcare worker. I understand that such testing is necessary to protect those who will be caring for the patient.

Purpose of Medical Photography

Your doctor may need to take photographs of the patient to document a medical condition, help with the diagnosis or treatment of a condition, and, or help plan details of surgery. Photographs taken for these clinical reasons do not require your written permission. Your written permission would be required for to use these photographs for non-clinical reasons such as publication.

Patient Signature: _____ Printed name: _____

Date: _____