

Consent To Use or Disclose Medical Information

I Authorize **ROUSE EyeCARE CENTER** to use and disclose the health and medical information of

_____ For the purposes of Treatment, Payment and Health Care Operations.
(Name of Patient)

- **TREATMENT** (includes activities performed by a physician, office staff, and other types of health care professionals providing care for you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician).
- **PAYMENT** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization).
- **HEALTH CARE OPERATIONS** (includes the necessary administrative and business functions of our office).

You may review **ROUSE EyeCARE CENTER** 'Notice of Privacy Practices' for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our Notice by placing your Initials here → _____ ←

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may also change, a summary of the Notice will be posted in the lobby of our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that **ROUSE EyeCARE CENTER** has already used or disclosed the information in reliance on this CONSENT.

CONFIDENTIAL PATIENT CONTACT PERSON: Based upon your written consent here-in, with the person specifically listed below is the only person to whom information will be released other than you, the patient.

Name _____ Relationship _____
Address _____
Telephone _____ Date of Birth _____

Date _____ Signature of Patient _____ (or)

Date _____ Signature of person authorized by law _____



ASSIGNMENT / RELEASE OF INFORMATION / FINANCIAL GUARANTEE / AUTHORIZATION TO TREAT:

I give my permission to ROUSE EyeCARE CENTER to bill my insurance company whether the benefits are paid to me or to ROUSE EyeCARE CENTER. It is my understanding that I am eligible for medical and/or vision benefits through my insurance(s). However, in the event that my insurance company categorizes services rendered to me as "non-covered" or "not medically necessary". I agree to pay in full for all such charges. I understand that I am financially responsible for all charges whether or not paid by insurance. I fully understand that it is my responsibility to advise ROUSE EyeCARE CENTER if my insurance requires a prior referral, prior authorization, pre-treatment review, pre-treatment authorization, or a second opinion, or if it contains any special provisions (to include exclusionary rider) which must be satisfied before payment by the insurance company can be made. If I fail to advise ROUSE EyeCARE CENTER of such policy requirements and to comply in good faith, I agree to pay in full for all such charges. If I am a member of a managed care plan, I understand that it is my responsibility to make sure the correct referral is in place from my Primary Care Provider or Manager. (Co-pays will be made at time of service). I understand I will be financially responsible for any and all charges at the time of service should a referral not be supplied by my Primary Care Provider or Manager.

Our policy is to charge \$50.00 for no-show, missed appointments, and late cancelations-reschedules. If you are unable to keep your appointment, please notify ROUSE EyeCARE CENTER 24 hours prior to your appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better and other patients by keeping your regularly scheduled appointments.

I further authorize ROUSE EyeCARE CENTER to exercise its medical judgment in determining the level of service, and to perform any tests or procedures deemed necessary to provide the appropriate eye care.

The signature below authorizes direct assignment, release and authorization to treat.

Patient Signature: _____
or Responsible Party signature

Patient Name (printed): _____

Date: _____

How did you hear about us? _____