Gadsden Eye Associates, P.C.
429 South Third Street
Gadsden, AL 35901

Patient's Name______________________________ **Account No.**_______________

Consent for Treatment / Financial Agreement: I consent to treatment necessary or desirable for my care including but not restricted to whatever drugs, medicines, performances of operation that may be used by the attending doctor, his/her medical assistant, or qualified designate. I also acknowledge full responsibility for the payment of these services. I understand that I am solely responsible for payment of all services though the insurance may be filed. **If my account becomes delinquent I agree to pay all costs of collection, including a reasonable attorney's fee.**

I understand that some services are not always covered as dictated by my insurance company based on the medical necessity. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure I will be billed for those services. I also acknowledge that as a member of these plans my insurance will be submitted by this office and **I will be responsible for paying all copays, deductibles, and non-covered services at the time of the visit.**

I understand that if my insurance is **Medicaid** I must obtain a referral from my Primary Care Physician for every visit before coming to this office for any appointments. I understand that it is my responsibility as the patient to confirm that my referral is current and in effect and that my benefits have not been exhausted when I arrive for my appointment. **If no referral is obtained or if my benefits have been exhausted and the claim is denied I understand that I will be financially responsible for payment of the visit.**

I understand that if my insurance is an **HMO** I may be required to obtain a referral from my Primary Care Physician prior to coming to this office for any appointments. I understand that is it my responsibility to know the requirements of my HMO and to be responsible for contacting my Primary Care Physician to request a referral for any appointments. **If no referral is obtained and the claim is denied I understand that I will be financially responsible for payment of the visit.**

Vision Plans: I agree to inform Gadsden Eye Associates if I have vision insurance that I wish to use for a **routine vision exam** on the date of my appointment. I understand that my vision plan may require an authorization in order to pay my claim. I understand that if no authorization is obtained or if I have exhausted my benefits and the claim is denied for either of these reasons I will pay for the visit. I understand that if Gadsden Eye Associates does not participate in my vision plan I will be required to pay for the visit in full at the time of service. I understand that vision plans do not cover services for medical conditions and if my doctor treats me for a medical condition during this same visit my medical insurance will be billed instead of my vision insurance. **I understand and agree to be responsible for payment of my medical insurance co-pays, deductibles and non covered services if my doctor treats me for any medical condition.**

Refraction Fees: I understand a **$40** refraction fee will be charged in addition to the exam fee if refraction is performed. (Refraction is a test that determines your eyeglasses or contact lens prescription. It is usually covered under vision insurance plans. However, most medical insurance plans including Medicare do not pay for the refraction fee and consider the fee to be a non-covered service that is the responsibility of the patient.) **I agree to pay the refraction fee if my insurance plan does not cover payment of this fee.**

I authorize my insurance company to remit payment of medical or vision benefits directly to this office for services provided by our doctors.

I hereby authorize the release of my medical records to the referring and family physicians as well as all records necessary for the processing of insurance claims.

____ Date:________________
Signature of Patient or Responsible Party

____ Date:________________
Signature of Co-Responsible Party

Patient Authorization for Disclosure of Protected Health Information via Alternative Means

Form 7.34

Please print all information, then sign and date authorization form at bottom.

Patient Name: ______________________________ **Date of Birth:** ____________

Purpose of Authorization – It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, *"by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care."* The practice requires the following authorization for release of protected health information (PHI) via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

☐ cell phone: ☐ email address: ☐ US Mail: ☐ fax number: ☐ phone:

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Description of information to be disclosed - I authorize the practice to disclose the following PHI about me. *(Provide a written description of the information to be disclosed.)*:

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Purpose of disclosure – I am authorizing the alternative means of communication for disclosure of my PHI to ensure the confidentiality of communications from the practice.

Expirations or termination of authorization – This authorization will renew automatically, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

(Please list desired expiration date): 1 Year

Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in person or by mailing a written request to the practice, Attn: Privacy Manager.

Non-Conditioning Statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

Redisclosure Statement – I understand that the practice has no control regarding persons who may have access to the mailing or email address, telephone, cell or fax number I have designated to receive my PHI. Therefore, I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.

Secure Communication – Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email as your preferred method of communication if this is of concern to you.

______________________________________ ____________

patient signature date

Copies of signed authorizations are available upon request.