CONSENT FOR TREATMENT/FINANCIAL AGREEMENT

Patient's Name:_____Account #_____

I consent to treatment necessary or desirable for my care including but not restricted to whatever drugs, medicines, performance 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 Medicaid 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 a **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 it is my responsibility 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 **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 conditions.**

Refractions 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.

_____Date:_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____Date:_____

SIGNATURE OF CO-PARTY