Citywide Eye Care

Acknowledgment

1) **Insurance Authorization and Patient Responsibility**

I authorize the release (or my dependent) of medical information necessary to process this claim, and assign medical benefits to myself or the named provider or assign directly to Citywide Eye Care, all insurance benefits, if any, otherwise payable to me for professional services rendered. I further understand and agree that I am financially responsible for all charges whether or not paid by insurance. I am responsible for all co-payment and /or deductible and coinsurances, and for any uncovered service. I hereby authorize Citywide Eye Care or the named provider to release all information necessary to secure the payment of benefit.

2) **Insurance Signature on File**

If I am covered under Medicare or other insurance, this will serve as your file copy of my "signature on File" for submitting Medicare and other insurance claims and accepting Medicare assignment on my behalf.

3) **Receipt of Notice of Privacy Practices**

I have read, understand and agree to the Notice of Privacy Practices. I further acknowledge that a copy of this notice will be available upon request. My signature below indicates that I read, understand and agree to the above authorization and acknowledgments.

4) For refractive Eye Examinations:

Eyeglasses and Contact Lens Prescription Signed Acknowledgment and Refund Policy

My signature below indicates as an electronic consent that I have received a copy of my eye glasses and or contact lens prescription after the exam in the **printed** prescription form or **electronically**. I have also read, understand and agree to the Eyeglasses and Contact Lens Refund Policy. I further acknowledge that a copy of this notice will be available upon request.

Please check if you want your prescription printed _____ or sent electronically _____.

5) **Consent for Taking and Publishing Photographs and/or Recordings**

My signature below indicates that I have read, understand and agree to the Consent for Taking and Publishing Photographs and/or Recordings. I further acknowledge that a copy of this notice will be available upon request.

6) If there's an acknowledgement that you would like to exclude, please list it here:_____

Print Name: _____Relationship to Patient:_____

Patient or authorized signature: _____ Date: _____

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