DR JEFFREY CALHOUN – Optometrist
DR TIMOTHY SCHWACH – Optometrist

CONSENT TO THE RELEASE OF MEDICAL INFORMATION:

- I authorize the release and disclosure of any and all of my medical records to any other entity including but not limited to, referring physicians, hospitals or other health care providers, which may be of assistance in the opinion of this office in providing for the treatment of the patient.
- I authorize this office and its employees to release and disclose all of any part of the patient's medical records to any entity which is, or may be, liable for all or any part of the provider coverage.
- I authorize the release of medical records necessary to assist in the reimbursement of benefits to which I may be entitled. I authorize this office and its employees to release via via fax and/ or electronic/internet transmission of medical records, which are needed in order to provide the patients with the appropriate medical care.

CONSENT TO FINANCIAL RESPONSIBILITY:

- All fees are due and payable at the time when services are rendered unless arrangements have been made with the Doctor and/or appropriate staff.
- We will accept direct assignment of your claim if it is allowable. However, please know that you will still be responsible for any non-covered services, such as deductibles, co-pays or co-insurance, etc.. If your claim is denied, please know that you will be responsible for the services rendered.
- You are responsible for charges incurred from an overdrawn account. It is our policy to charge a fee of $25.00 in addition to the billing charges for incurred bank surcharges.

INSURANCE COVERAGE WAIVER:

- I understand that if my eligibility for coverage by my insurance cannot be confirmed at this time, I still wish to receive medical services from Dr. Jeffrey Calhoun and Dr. Timothy Schwach. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment for all services provided.

REFERRAL WAIVER:

- I understand that if my insurance company requires a referral and I do not obtain a referral, I will be responsible for payment for all services provided. It is the patient's responsibility to know if a referral is required.

CONSENT FOR THE ASSIGNMENT OF BENEFITS:

- I authorize direct payment of medical benefits to this office from the listed insurance carrier. The signature furnished below shall suffice for all forms on a continuing basis.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

- I acknowledge that I have received a copy of this office's Notice of Privacy Practice and/or it is posted and readily available for me to read.

I consent to all of the above:

Patient Name (please print) _____

Patient Signature (over age 18) x_____ Date _____/_____/_____

If patient is under 18 yr. old:

Guarantor Name (please print) _____

Relation to Patient _____

Guarantor Signature (under age 18) x_____ Date _____/_____/_____