INSURANCE / MEDICARE AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance/Medicare coverage and assign directly to Ophthalmology Associates all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

Ophthalmology Associates may use and disclose my health care information to the insurance companies and/or the Centers for Medicare and Medicaid Services, and their agents for the purpose of obtaining payment for services and determining benefits or the benefits for related services.

IT IS YOUR RESPONSIBILITY TO INFORM US AT THE POINT OF SERVICE IF YOU HAVE INSURANCE COVERAGE FOR ROUTINE EYE SERVICES.

Signature of Patient, Parent, Guardian or Personal Representative	Patient's Date of Birth	Today's Date
	___/___/___	___/___/___

Printed Name	Relationship to Patient **if other than patient**

HIPAA – Consent for Purposes of Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, Ophthalmology Associates creates and maintains health records describing my health history. I understand that Ophthalmology Associates may use this information as:

1. A basis for planning my care and treatment;
2. A means of communication among many health professionals who contribute to my care;
3. A means by which third-party payers (insurance companies) can verify that services billed were actually provided; and
4. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided a Notice of Ophthalmology Associate's Privacy Practices, which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Ophthalmology Associates reserves the right to change its notice and practices, and I will be provided a revised copy. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or other healthcare operations, and that Ophthalmology Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Ophthalmology Associates has already taken action in reliance on it.

I hereby consent to the use, retrieval and disclosure of my personal health and pharmaceuticals information by Ophthalmology Associates for purposes of treatment, payment and healthcare operations.

Signature of Patient, Parent, or Representative	Today's Date	**Printed Name of Patient**
	___/___/___	

Printed Name of Person Listed Above **if other than patient**	Relationship to Patient

I give consent to Ophthalmology Associates to release any and all health care information and results to the persons listed below:

NAME	RELATIONSHIP	PHONE NUMBER