2020, INC.

ON-SITE OPTOMETRY

("Practice")

ACKNOWLEDGEMENT & GENERAL CONSENT FORM

Patient Name: _____
Last **First** **Middle**

Home Address: _____

Home Phone: _____ **Cell Phone:** _____

Date of Birth: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

CONSENT TO TREATMENT
By my signature below, I do hereby voluntarily consent to treatment by optometrists of the Practice for an eye exam and to any related diagnostic procedures and treatments as necessary in the judgment of the optometrist. I acknowledge that the practice of optometry is not an exact science. I acknowledge that no guarantees have been or can be made to me as a result of such procedures and treatments.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the health care operations of the Practice (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary for purposes of my treatment, payment for that treatment, and for their health care operations.

By my signature below, I also authorize the Practice to communicate with me by phone (using the numbers listed above) and to disclose my general health information on my home answering machine/voicemail and on my cell phone voicemail, and to my spouse, children, and the following additional family and friends:_____.

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY
By my signature below, I understand that it is my responsibility to supply the Practice with current insurance information and/or any referral authorization forms that may be necessary for my insurance. I am aware that if I have a routine diagnosis my insurance may not cover the examination. I understand that insurance companies require beneficiaries to pay deductibles, company insurance, co-payments, and any non-covered services at the time services are rendered.

I am aware that I am responsible for any unpaid balances. I authorize the Practice to charge my credit card on file or send an invoice for any outstanding balance. If my account results in collection agency involvement, the undersigned, guarantor receive all payments for services rendered to me or my dependents.

By my signature below, I agree to all of the above while I am a patient of the Practice.

_____ _____
Signature of Patient **Date**

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signature:

_____ _____ _____
Signature of Personal Representative **Description of Authority** **Date**