EYECARE
PROFESSIONALS

101 Eastern Boulevard North
Hagerstown, MD 21740
(240) 420-8888

CONSENT FOR MEDICAL TREATMENT AND RELEASE OF INFORMATION

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Eyecare Professionals.
2. **Authorization for Release of Information:** Eyecare Professionals may release information from my medical records to any health care provider involved in my care and treatment. Eyecare Professionals may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, and the Medicare programs.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Eyecare Professionals which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If a payment is not made within 90 days from the date the bill was mailed from Eyecare Professionals, I understand that a delinquent charge of interest at the rate of 15% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be refunded in the same way as the original payment. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.
4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorization and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Eyecare Professionals charges.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance benefits for health care services or goods may be made directly to Eyecare Professionals.
6. **Charge for No Show/Cancellation without 24 hour notice:** I understand that 24 hour notice is required for canceling an appointment and I will be charged a $35.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be charged for that day.
7. **Charge for Refraction:** I understand that a refraction may be necessary for the doctor to fully evaluate my condition and I will be charged $49.00 for this service by Eyecare Professionals. I also understand that I will be responsible for this charge and that my insurance company will not be billed for this service.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices from Eyecare Professionals.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

Authorized Individuals: These individuals are allowed to have information concerning my health conditions.

Name: _____ Relationship: _____

Name: _____ Relationship: _____