Patient Authorization

P: 815-756-8571
F: 815-756-5603

*_____ **Privacy Notice**
(Initials) I acknowledge that I have received a copy of the Notice of Privacy Practices from the Hauser-Ross Eye Institute either today or since April 14, 2003.

*_____ **Release of Information and Assignment of Benefits**
(Initials) I hereby authorize the Hauser-Ross Eye Institute to release information to anyone listed on the patient registration from or this authorization form, as well as any of my insurance companies. I request payment of authorized health insurance benefits (Medicare, all commercial insurance, Medicaid, etc.) be made to either me or on my behalf to the Hauser-Ross Eye Institute for any services furnished by that institution

*_____ **Patient Financial Responsibility**
(Initials) I acknowledge full financial responsibility for services rendered. I understand that I am responsible for prompt payment of any amounts due including, but not limited to: co-pays, deductibles, and coinsurance amounts. I understand that payment of co-pays are expected at time of service, as well as any prior balances I may owe. I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to HREI for any medical, imaging, and/or surgical services furnished. I accept responsibility for all charges not covered by insurance or other third party payers. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policy guidelines.

*_____ **Consent to Treat**
(Initials) I hereby authorize the consent to the administration and performance of such medical treatments and diagnostic procedures as may be deemed necessary during the course of my appointment by my physician or his/her assistants. I understand that not following medical advice and treatment recommended by my doctor may cause or contribute to poor outcomes including loss of vision and/or loss of life. I have been advised that my examination may include dilation of the pupils, which may impair my ability to drive. This consent will be updated yearly.

*_____ **Authorization to Leave Messages**
(Initials) Your initials in this section indicate that it is acceptable to leave a voice mail message when we call you and you are not available. If this is NOT acceptable, please let us know at registration.

*_____ **Missed Appointment Policy**
(Initials) In order to better serve our patients, the Practice will allow one missed appointment. After the first missed appointment, a $25 service fee will be charged. You will be responsible for the service fee payment, as insurance companies do not cover missed appointment fees. Please note that there will be no charge if 24-hour notice is given for a cancellation.

Other than the Patient or Parent/Guardian, please list anyone who may be authorized to receive information regarding your care at the Hauser-Ross Eye Institute.

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_____ _____
Signature of patient or authorized representative Date

_____
Relationship of signer to patient, if patient did not sign above (Patient Name, if different from above)