CONSENT FOR CARE
ASSIGNMENT OF BENEFITS
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, the undersigned, consent to the use and disclosure of my protected health information by Eye Consultants, Incorporated for the purpose of carrying out my treatment, obtaining payment for my health care or for carrying out health care operations. I further consent to students, including but not limited to medical, nursing and other healthy related students, observing and participating in my care under the supervision of a physician at Eye Consultants, Incorporated.

I understand that I have a right to review Eye Consultants, Incorporated's Notice of Privacy Practices prior to signing this document. I hereby acknowledge that I received a copy of Eye Consultants, Incorporated's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Eye Consultants, Incorporated may use and disclose protected health information about me. A copy of this Notice of Privacy Practices is also provided in the waiting area of Eye Consultants, Incorporated.

Eye Consultants, Incorporated reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I acknowledge that I have the right to request that the use of my protected heath information be restricted in carrying out my treatment, obtaining payment for my health care or for carrying out the health care operations. However, I understand that Eye Consultants, Incorporated is not obligated to agree to any such restriction, except as required by law. If Eye Consultants, Incorporated and I agree upon any restrictions, such restrictions will be in writing and both Eye Consultants Incorporated and I will agree to terminate any such restriction in writing.

My "protected health information" includes all individually identifiable information which is created or received by Eye Consultants, Incorporated and which relates to my past, present or future physical or mental health or condition, the provision of health care to me or to the past, present or future payment for the provision of health care to me.

I hereby assign all medical, surgical, and/or third party payer benefits to which I am entitled, including private insurance, Medicare and/or any other health plan to: **Eye Consultants, Incorporated** for any services furnished me by Eye Consultants, Incorporated. I authorize Eye Consultants, Incorporated to release any medical information to such private insurance, the Centers for Medicare & Medicaid Services and/or any other health plan to the extent such information is needed to determine benefits or benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. If the above services are being provided to a minor, the personal representative below agrees that he/she is financially responsible for all charges whether or not paid by said insurance.

I also hereby authorize Eye Consultants, Incorporated to release and/or discuss my protected health information to the individuals listed on the back of this form.

A photocopy or fax copy of this consent and assignment of benefits is to be considered as valid as the original.

Signature of Patient or Personal Representative	Date
Name of Patient or Personal Representative	Description of Personal Representative's Authority

AUTHORIZED INDIVIDUALS

Name: _____

Address: _____

_____

Phone: _____

Relationship:_____

Name: _____

Address: _____

_____

Phone: _____

Relationship:_____