ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received a copy of Eye Associates Northwest, PC's Notice of Privacy Practices. **Initial** _______

AUTHORIZATION TO OBTAIN MEDICATION LIST ELECTRONICALLY

I give permission to Eye Associates Northwest, PC to obtain a list of my medications using Surescripts, Health Information Network. **Initial** _______

AUTHORIZATION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

I hereby authorize medical providers and personnel of Eye Associates Northwest, PC to discuss my protected health information including appointment, billing and treatment information with:

_________________________________ _________________________________
Name Relationship

_________________________________ _________________________________
Name Relationship

CONSENT FOR MEDICAL TREATMENT

I hereby consent to all medical treatment or services performed by physicians and staff of Eye Associates Northwest, PC. This includes pupillary dilation and refraction, or any services deemed medically necessary by my provider. I understand that my authorized representative or I have the right to accept or refuse medical care at any time. **Initial** _______

MISSED APPOINTMENT & CANCELLATIONS

Appointments not kept or cancelled within 24 hours notice prior to the scheduled appointment time may be charged a $75.00 cancellation fee. These charges cannot be billed to your insurance company and will be your responsibility. Missed appointment fees must be paid at the next scheduled appointment. If you miss 3 appointments without proper notice, all future appointments will be cancelled. **Initial** _______

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I acknowledge my financial responsibility to pay for all services received from Eye Associates Northwest, PC physicians and staff regardless of insurance coverage, eligibility or referral status.

I understand Eye Associates Northwest, PC will bill my insurance based on the information I provide and any unpaid charges will be my responsibility. This responsibility includes any charges not paid by my insurance carrier, including charges deemed non-covered.

I authorize release of any medical information necessary to process my insurance claim and also assign to Eye Associates Northwest, PC all payments from Medicare and/or other insurance providers for services rendered.

I give my consent to Eye Associates Northwest, PC and to any of its agents acting on its behalf to communicate with me regarding my accounts through various means such as 1) any cell, landline, or text number that I provide 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

I acknowledge that failure to provide prior authorization and/or written referral, if required by insurance, will result in all charges becoming my responsibility.

If the patient is a minor, I confirm that I am financially responsible for services provided to the patient. **Initial** _______

My signature indicates I have read and agree to the contents above.

Print Patient Name: ______________________________ **Relationship (if not patient):** ____________________________

Patient Signature (or Parent/Guardian): ____________________________ **Date of consent**: _____________________