

Payette Family Eyecare

DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge that I have received a copy of Payette Family Eyecare’s notice of Privacy Practices.

PATIENT SIGNATURE

DATE

I hereby authorize the following people to be made aware of my test results, appointment times, medical information and patient account status. I understand that if someone inquires about any of the information listed above and is NOT listed on this consent form, information will NOT be released. We must have a signature authorizing release of any medical information.

NAME/RELATIONSHIP TO PATIENT

NAME/RELATIONSHIP TO PATIENT

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NAME/RELATIONSHIP TO PATIENT

NAME/RELATIONSHIP TO PATIENT

NAME/RELATIONSHIP TO PATIENT

AUTHORIZATION

I authorize Payette Family Eyecare to release any medical information pertaining to my care to my referring physician, any physician I am referred to from this office, and any other physician/office participating in my care. I authorize treatment from this office and payment of medical benefits to the physician/supplier for those services rendered not to exceed the total billed charges for those services. I authorize the release of any information necessary to process insurance claims and I certify the information contained herein is correct. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment of benefits apply.

PATIENT SIGNATURE

DATE

PATIENT’S NAME(PLEASE PRINT)

FOR OUR MEDICARE PATIENTS

After you are seen by the doctor, Payette Family Eyecare will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation “SIGNATURE ON FILE” will appear *in lieu* of your signature on all Medicare forms submitted for you by our office.

X _____
Signature of Medicare Beneficiary