ARKANSAS EYE SITE

Patient Name: _____

Date of Birth: _____

Authorization to Release Patient Information:

I, _____, hereby authorize Arkansas Eye Site to discuss and release any medical information to the persons named below. This includes glasses/contact lens pick-ups, appointment information, and permission to contact them if unable to reach me when necessary.

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Initials: ____

Assignment of Benefits:

I request payments by Medicare, Medicaid, medical insurance companies and other third party payers be made payable to my healthcare providers. I authorize my physicians and healthcare providers to release my Protected Health Information (PHI) to the healthcare Financing Administration, insurance companies, and other providers of medical services as may be necessary to provide for my clinical care and/or to determine my financial benefits or coverage's, in compliance with HIPAA and other applicable laws. I hereby acknowledge I have received a Notice of Privacy Practices. I understand and agree I am responsible for any charges not paid for by my insurance.

Initials: ____

Refraction Authorization:

Refraction is the process of the doctor checking your glasses or contact lens prescription. Medical insurances do not cover this charge because it is considered to be routine vision and not medically necessary.

The charge of $20.00 is due at the time of service.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE.

o **Option 1: YES, I want to receive these items or services.**

I understand that my Insurance Company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill while my Insurance Company is making its decision. If my insurance company does pay, you will refund me any payments I made to you that are due to me. If my Insurance Company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my Insurance Company's decision.

o **Option 2: NO, I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company will not pay.

Signature of Patient or Legal Guardian: _____ Date: _____