Peter K. Mocklis, O.D. Marcy V. Schultenover, O.D. Wendy Crusberg, O.D. Michael E. Johnson, O.D.
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Patient Consent Form

Consent for Treatment: I do hereby voluntarily consent to examination by Lens Doctors and to the rendering of such care and medical treatment as may be deemed necessary or appropriate by the physicians and other clinical personnel of the practice.

Release of Information: I authorize the practice to use or disclose my health information (1) for treatment purposes, (2) in connection with payment or reimbursement for health services or materials provided to me, or (3) for the purpose of carrying out Practice operations. Such disclosure may be made to any person, company or agency which is or may be responsible for all or part of charges for my treatment and/or examination- including but not limited to insurance companies, medical service companies, managed care organizations, worker's compensation carriers, peer review organizations, government agencies or other responsible parties, all or part of my medical information or records in connection with payment for or establishing the medical necessity of my admission or treatment, or as otherwise required by law. I ALSO AUTHORIZE THE RELEASE OF SUCH INFORMATION TO OTHER TREATING OR CONSULTING PHYSICIAN(S) AS WHO MAY BE INVOLVED IN MY CARE. (In connection with the use of disclosures of my medical information, I acknowledge the Practice has offered me a copy of Privacy Practices for review and to keep for my records on the date identified below.) I can be assured that Lens Doctors does not sell my personal health information of any kind to a third party for such party's own use, regarding the vision services and products that I have received from Lens Doctors.

Signature of Patient/Patient Representative _____ Date_____

Financial Responsibility: In order to control the cost of billing, I understand that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials, i.e. the exam, the contact lens exam, eyeglasses, and contact lenses, are charged to the patient at the time of visit and at the time the material order is placed. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. If some fees are not paid by my insurance plan, I will receive a bill for any unpaid deductibles, co-payments, co-insurance, or non covered services as allowed by the insurance contract. Accounts 30 days old are subject to collection fees. I understand that any check for services returned for any reason will result in a fee of $30 which will be added to my account.

All HMO insurances require a referral for services from a valid PCP registered with my insurance. I UNDERSTAND IF A VALID REFERRAL FOR SERVICES FROM MY PRIMARY CARE PHYSICIAN IS NOT ACQUIRED BY ME BEFORE MY APPOINTMENT, I WILL BE RESPONSIBLE FOR ALL CHARGES AND FEES RESULTING FROM SAID VISIT.

Vision Insurance (such as VSP, Eyemed, Davis Vision, and Superior Vision): Vision insurance only applies to routine eye exams along with eyeglasses and contact lenses. Vision plans only cover basic screenings for eye disease, THEY DO NOT COVER DIAGNOSIS, MANAGEMENT, OR TREATMENT OF EYE DISEASE.

Medical Insurance (such as Blue Cross/Blue Shield, Harvard Pilgrim, Medicare etc.): Medical Insurance must be used if I have any eye health problems or systemic health problems that have ocular complications. My Doctor will determine if these conditions apply to me, however, it may also be determined by my case history. The test(s) needed to determine my refractive error (necessary for eyeglass prescriptions) IS NOT COVERED BY MEDICARE and some other medical insurances, and is, therefore, my responsibility.

Consent of Form: I have read the information provided in this form (or had such information read to me) carefully and in its entirety, have been given an opportunity to ask questions and have received satisfactory answers to my questions, if any. I understand the content of this form and agree to the terms contained herein. I certify that all information supplied by me as part of the registration process is correct.

_____ _____
Witness Date Patient Date

For any patient who is incapable of providing informed consent to medical treatment or assuming financial responsibility for payment of medical services, a legal representative of the patient must complete the following and sign on behalf of the patient.

The Patient is incapable of providing consent because (check one):

_____ The Patient is a minor who is _____ years of age.

_____ The Patient's mental or physical condition prevents him or her from being able to sign this form.

By my signature below, I certify I am authorized by law to provide consent on behalf of the Patient.

_____ _____
Witness Date Patient Representative Date

_____
Relationship to Patient