

Patient Consent Form

PLEASE READ CAREFULLY:

I understand that my medical records are confidential. I understand that by signing this consent form I am allowing the release of any information necessary to process my claims for medical or other insurance benefits.

I understand that it is my responsibility to pay **Killeen Eye Care Center** for the services and supplies provided regardless of any deductible, co-payments, or other variations in my individual insurance program. These are my rights and benefits under my insurance policy.

I give my permission to the **Killeen Eye Care Center** to release any information for the purpose of billing my claim to my carrier. Any information about my insurance or health is to be held in strict confidence for the sole purpose as noted.

MEDICARE/MEDICAID

If I have Medicare or Medicaid, the **Killeen Eye Care Center** agrees to accept assignment, and I authorize the **Killeen Eye Care Center** to bill my insurance carrier (providing any and all necessary information and documentation) for whatever benefits I am entitled.

TO MEDICARE PATIENTS

Federal law requires that we notify you when services to be provided may not be covered by them because it may not meet their guidelines. Vision exams are only covered if you have or are found to have a medical condition requiring eye care. Materials are only covered one time after a cataract surgery. This document serves as notice that if Medicare denies payment for this service, you will be responsible for payment.

I have read the above consent for release of information. I do hereby acknowledge that I am familiar and fully understand the terms and conditions of the consent.

Signature of Patient or Legal Guardian

X _____ **DATE** _____