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 Vision Source** 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 Vision Source** to release my 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 Vision Source** agrees to accept assignment, and I authorize the **Killeen Vision Source** to bill my insurance carrier (providing any and all necessary information and documentation) for whatever benefits I am entitled.

Medicaid Patient:

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 found to have a medical condition requiring eye care. Materials are only covered one time after cataract surgery. This document serves as notice that 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.

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that **Killeen Vision Source** make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ❑ I have read or had explained to me **Killeen Vision Source's** Notice of Privacy Practice and agree to continue my care with **Killeen Vision Source** under said terms.
- ❑ I was given the opportunity to read **Killeen Vision Source's** Notice of Privacy Practice and declined, but wish to continue my care with **Killeen Vision Source** under terms of **Killeen Vision Source's** the privacy policies.
- ❑ I have read or had explained to me **Killeen Vision Source's** Notice of Privacy Practice and do not wish to continue my care with **Killeen Vision Source** under said terms.
- ❑ The Notice of Privacy Practice could not be read due to the emergent nature of the care of the other reason described as:_____

_____

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

X_____ _____
Signature of Patient or Patient Representative Date

PLEASE COMPLETE BOTH SIDES OF THE FORM OVER→