**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chart #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***AUTHORIZATION FOR MEDICAL TREATMENT:***

I authorize Eye Surgical Associates to provide necessary medical care to: (Select) **SELF DEPENDENT**.

I understand I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my clinician.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Parent or Guardian if minor) Date

***PARTICIPATING INSURANCE COMPANIES:***

I authorize the release of any medical information necessary to process my claims. I also authorize payment of benefits to Eye Surgical Associates. I assume responsibility for any balance not paid by my insurance company, including copay, deductible, and/or co-insurance if applicable.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Parent or Guardian if minor) Date

***PRIVATE PAY AND NON-PARTICIPATING INSURANCE COMPANIES:***

I understand that Eye Surgical Associates does not participate with my insurance company.

I assume responsibility for payment of this account if my insurance does not pay or I do not have insurance coverage.

I understand that payment is expected at the time of the visit.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Parent or Guardian if minor) Date

***MEDICARE PATIENTS ONLY:***

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Eye Surgical Associates for any service furnished to me by my clinician. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services. I also authorize payment of all other medical benefits filed by Eye Surgical Associates to Eye Surgical Associates. I assume responsibility for any balance not paid by my insurance company, including copay, deductible, and/or co-insurance if applicable.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Parent or Guardian if minor) Date

***MEDICARE SECONDARY PAYER QUESTIONNAIRE: (to be completed by all Medicare Patients):***

1. Is the patient a Veteran? YES NO

If YES, does the patient authorize Eye Surgical Associates to bill the Veterans Administration?

YES NO

2. Is this medical condition due to an accident of any kind? YES NO

If YES, Was it work related? YES NO

Auto accident? YES NO

Injured at home? YES NO

Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Is this medical condition covered by another health plan through the patient’s current employer or their spouse’s employer? (Other than retiree coverage) YES NO

4. Is the patient currently residing in a skilled nursing facility (SNF)? YES NO

***CONSENT TO ELECTRONIC MESSAGING:***

I authorize Eye Surgical Associates and/or any third party organization assigned to the account to contact me via text at the cellular number and/or email provided.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Parent or Guardian if minor) Date