



**PAYMENT OF SERVICES:**

I understand that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier. I further understand that I am also responsible for non-covered services, such as the refraction fee of \$40.00. *It is my responsibility to inform Pacific Eye Surgeons of any changes in contact and/or insurance information in a timely manner.*

\_\_\_\_\_  
Patient Signature (or Responsible Party if patient is a minor)

\_\_\_\_\_  
Date

**MEDICARE AUTHORIZATION:**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Pacific Eye Surgeons, Inc. for any service furnished to me. I authorize my holder of medical information about me to release to the Health Care Financing Administration and its Agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient Signature (or Responsible Party if patient is a minor)

\_\_\_\_\_  
Date

**INFORMATION RELEASE AUTHORIZATION:**

I, \_\_\_\_\_, give Pacific Eye Surgeons, Inc. my authorization to use or disclose my protected health information for use by specialists if referred by my treating physician, and understand that it will only contain the minimum health information necessary regarding the illness or injury. I further authorize Pacific Eye Surgeons, Inc. to release the minimum necessary health information concerning my diagnosis and treatment for the purpose of securing payment from my insurance company, and hereby authorize payment of the insurance benefits directly to the doctor for and services rendered that are not paid for directly by me.

\_\_\_\_\_  
Patient Signature (or Responsible Party if patient is a minor)

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES**

I understand that under the “Health Insurance Portability & Accountability Act of 1996” (HIPAA), that I have certain rights to privacy regarding my protected health information (PHI). **I understand that this information can and will be used to: 1) Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly; 2) Obtain payment from third party payers; 3) Conduct normal healthcare operations such as quality assessments and physician certifications.**

I acknowledge that I have been informed and had access to Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Pacific Eye Surgeons has the right to change their Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

**I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.**

\_\_\_\_\_  
Patient Signature (or Responsible Party if patient is a minor)

\_\_\_\_\_  
Date