

Agreement of Responsibility

I understand the professional services are rendered to the patient and the patient is responsible for the charges incurred. I understand I am financially responsible for the charges not covered by my insurance company. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I have received and reviewed the payment policy and agree to the conditions set forth in such policy. I understand I will receive a monthly statement for any balance due by me.

Initial: _____

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Initial: _____

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received a copy of Omni Eye Specialist's P.A. Notice of Privacy Practices.

Initial: _____

No change in information

I have reviewed the patient information provided on my previous registration and there are no changes in my address or insurance coverage since that time.

Release of Information/Assignment of Benefits

I authorize the use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of an original. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered.

Name: _____ Date: _____

Signature: _____