Hart Family Eyecare, LLC

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CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

Name:_____

1. **Consent for Health Care Service:** I authorize consent for medical treatment at Hart Family Eyecare, LLC.
2. **Authorization for Release of Information**: Hart Family Eyecare, LLC may release my information from my medical records to any health provider involved in my care and treatment. Hart Family Eyecare LLC may also release information from my medical records to any person or organization liable for any part of my charges such as my insurance carrier, any third-party payer, Medicare programs and my employer's Workman's Compensation carrier. I acknowledge that upon disclosure of my medical record information to an insurance company or other payer pursuant to this authorization, Hart Family Eyecare, LLC is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Financial Agreement**: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Hart Family Eyecare, LLC which are not paid by my insurance or other payer. All charges are due and payable upon receipt of a statement. I agree to pay all reasonable legal expenses necessary for the collection of the debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Hart Family Eyecare, LLC. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charge.
4. **Pre-authorization Requirements**: I accept the responsibility to obtain all referrals or pre-authorizations and comply with requirements of any insurance or medical coverage plan upon which I am relying on for medical coverage of Hart Family Eyecare, LLC charges.
5. **Assignment for Direct Payment**: I authorize that payment of any insurance benefits for healthcare services or goods may be made directly to Hart Family Eyecare, LLC.
6. **Collection charges**: I understand that if my account is turned over to a collection agency a fee of 35% will be added to my account balance.
7. **Materials:** Contact Lenses and Eyewear will be held for no longer than 30 days. I understand that I will forfeit my deposit, copays, and insurance benefits if not picked up within that time frame.

I acknowledge that :

I have read this form and understand its contents. I am the patient or persons duly authorized either by the patient or otherwise, to sign the agreement, consent to, and accept its terms.
I am responsible for payment and/or co-payment that is due at the time of service. I understand a copy of the HIPAA policy is available to me upon request at Hart Family Eyecare, LLC.

_____ _____
Signature of Patient or Legally Responsible Name (Print)

_____ _____
Relationship if not Patient Date