

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Visionary Optometry**

**General Consent**

**Consent for Medical Treatment:** I give consent to Visionary Optometry, its staff, physician and other practitioners of (the “Practice”) to provide and perform such medical care, tests, procedures and other services that are deemed necessary or beneficial by the Practice for my health and well-being.

**Authorization of Payment of Insurance Benefits:** I authorize payment to the Practice of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care and treatment to cover the costs of care and treatment. I hereby authorize the release of any/all medical records about me for the purposes of payment of the services rendered.

**Financial Agreement:** I agree that in consideration for the services rendered to me, to pay all amounts for which I am financially responsible, in accordance with the rates and terms of the Practice. I understand that where insurance or other third-party benefits are insufficient to pay all of the services rendered, that I will be responsible for the payment of any balances due as determined by the respective provider of services, including deductibles, copayments, co-insurance or other fees required by insurer, HMO, or other benefit plan. I understand that if I have not provided the Practice with accurate and current information regarding my insurer at the time of service, HMO or other benefit plan/third-party payor which provides me with health care coverage, I will be responsible for the cost of all care rendered by the Practice. I agree to pay all bills when presented. I understand there will be a $25.00 charge for all returned checks; and a $25.00 fee for all no shows/appointments not cancelled 24 hours prior to my appointment time.

**Release of information:** I understand that the Practice will release my information: (1) to any requesting health care provider for my further diagnosis, care or treatment or for that provider’s payment or health care operation purposed; (2) to any person or entity which may be responsible for billing/collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to the Practice or me for all or part of the Practice’s charges, including but not limited to, insurance companies, HMO or third-party payors; (4) to any government agency or other organization responsible for oversight of the Practice or a third-party payor; (5) for the Practice’s normal health care operations. I understand that the Practice may communicate information including Protected Health Information with me through text or email and through the Practice’s electronic health record system.

Patient/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_