OPTOMETRY CONSENT

Facility Name_____

I hereby request an optometry evaluation and treatment for:_____
(print patient name)

Patient Date of Birth_____

Medicare #_____ Medicaid #_____

Medicare Replacement Plan_____ ID#_____

Supplemental Insurance_____ ID#_____

***Sign Here** _____ **Date**_____
(signature of patient, guardian, or responsible party)

All bills shall be directed towards Medicare and insurance carriers when possible. Patient is responsible for the deductible and co-insurance when not covered by supplemental insurance or Medicaid. I authorize Medicare and my insurance carriers to send payments directly to the optometrist. I also authorize the release of any information from any agency or carrier to the optometrist for purposes of administering the Medicare program. I authorize the optometrist to release any required information to any agency, insurance carrier, or Medicare as needed. I have read and understand the facility's &/or the optometrist privacy policies regarding the handling of protected health information.

PRIMARY CARE DOCTOR AUTHORIZATION:

I am authorizing this patient to have an annual eye health exam with an optometrist.

Primary Care Doctor Signature_____