Patient Name: _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, certify that I(or my dependent), have insurance coverage with_____ and assign directly to Dr. Beats and/or Dr. Murrell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

Responsible party signature_____Date_____

Relationship to insured_____

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

I acknowledge that I have received a copy of Broken Arrow Vision Clinic's privacy policy.

Signature_____Date_____

DILATION CONSENT

This eye exam includes a dilated assessment of the retina. The procedure consists of putting drops in the eyes to widen the pupil, in order to allow the doctor to view all portions of the retina. The drops cause the eyes to be sensitive to light and cause your near vision to be blurry for approximately 4-6 hours.

This is an elective procedure and if you do not want to have it performed please indicate below. If you have any further questions, please do not hesitate to ask the doctor.

☐ Yes, I want to have my eyes dilated today.

☐ No, I do not want to have my eyes dilated today.

Signature_____Date_____