FIRST STREET VISION

PLEASE READ AND INITIAL EACH APPLICABLE ITEM

Date: _____

Patient: _____

Guardian/POA: _____

_____ Account Responsible understands and agrees, regardless of my insurance status, that I am responsible for the balance of my account for any services rendered and materials ordered by First Street Vision. If my account is not paid, I understand that I will be responsible for all costs of account collection.

_____ By initialing, I consent to ocular health treatment for myself and/or on the behalf of the patient for which this information pertains. I give permission for the doctors to examine, diagnose, and initiate treatment/appropriate follow-up care as deemed necessary.

_____Medicare/Commercial Insurance/TennCare: I authorize the release to my insurance company any information needed to determine benefits for services. I permit a copy of this authorization to be used in place of the original. I also request payment of benefits be made on my behalf to First Street Vision.

_____ I understand should my insurance company pay less that estimated that I will be responsible for payment of those fees that the insurance company identifies as my financial responsibility.

_____HIPPA: I understand First Street Vision will protect my medical/personal information and release only to another doctor for treatment, an insurance company, or to obtain payment. I understand I have the right to complain to one of the staff at the clinic should I feel my rights have been violated. I understand that a copy of First Street Vision's privacy policy will be given to me only upon my request.