PREMIER EYECARE &OPTICAL

PATIENT AUTHORIZATION

I authorize any holder of medical records including Psychiatric, Alcohol, Drug Abuse and HIV/AIDS or other information about me to be released to the SSA or Health Care Financial Administrator or it's intermediaries or carrier, or any other insurance carrier, any information needed for this or a related claim. I permit a copy of the authorization to be used in place of the original, and request payment of the medical insurance benefit either to myself or to the medical party who accepts assignment.

Acknowledgement of Receipt for HIPAA Compliancy

I acknowledge that I've received a copy of *Premier Eyecare & Optical's* notice of Privacy Practices.

I, _____, allow the following person(s) to access my personal
(patient name)
and medical information on my behalf.

_____ Name _____Relationship

_____ Name _____Relationship

Patient's Name: _____

Parent/Legal Guardian Signature _____ Date _____

REFRACTION FEE NOTICE

Please Note:

Medicare, Medicaid, and most other insurance carriers ***WILL NOT*** pay for **Refractions** (testing for glasses) or **Routine Eye Exams** (exams for blurred vision, headaches, or yearly exams not related to medical diseases).

The fee for Refractions (testing to determine your prescription) is $20. This fee **PLUS** any co-payment or deductible is **DUE AT THE TIME OF SERVICE**.

**** If you have any insurance, we will be glad to help you file for any benefits to which you are entitled. However, it remains the responsibility of the individual patient to settle his/her account promptly. ****

I agree to be responsible for payment of services rendered.

_____Date_____
Signature of Patient (or Representative)