

Pediatric Eye Specialists Signature Authorization Page

Patient's Name _____

Information Release

I authorize the providers of Pediatric Eye Specialists, LLP, to release any information obtained in the course of my/my child's evaluation and/or treatment to my insurance company(ies), previous physician (s) and/or attorney(s). I further authorize any other medical provider of services to release full details of the condition I seek medical treatment for with Pediatric Eye Specialists, LLP.

Initials

Direct Payment

I authorize payment directly to Pediatric Eye Specialists, LLP for the amount due in my/my child's pending claim for medical expenses payable under the terms of my insurance. I agree that I am responsible for any service or supply that may not be covered by my insurance.

Initials

Balance Payment

I agree that I am responsible for any balance not paid by my insurance or any other third party. I understand that if I fail to resolve any balance determined to be my responsibility, a report may be filed to a credit-reporting agency.

Initials

Photographic Release – Clinical Records

I authorize the providers of Pediatric Eye Specialists, LLP to take necessary clinical photographs with the understanding that such photographs are for confidential clinical record purpose. If my insurance company requires photographic medical records to process my claim, I authorize the release of those photographs for that purpose.

Initials

Change of Information

I will use best efforts to notify Pediatric Eye Specialists, LLP of any change in my information (**address, telephone numbers, insurance company**) in a timely manner. Should I fail to notify Pediatric Eye Specialists, LLP of a change in my insurance carrier, I agree I will be responsible for any charges not payable due to my failure to obtain any necessary referrals or authorizations. I realize that this is my responsibility when seeking the care of a specialist.

Initials

I have read and fully understand the above statements. I agree that I am bound and hereby give my consent.

Parent or Adult Guardian Signature

Date

Adult Patient

Date