OHIO OPHTHALMOLOGY

Consent for Medical Treatment:

I give permission for Ohio Ophthalmology to provide me medical treatment. I hereby consent to such care and treatment by Ohio Ophthalmology physicians and staff. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as the result of such treatment and examination.

Insurance/Coverage:
I give my permission to Ohio Ophthalmology to file for insurance benefits on my behalf to pay for the care that I receive. I request that payment of authorized Medicare benefits be made on my behalf to Ohio Ophthalmology for any services furnished to me by their physicians and staff. I authorize release to Health Financing Administration and its agents any medical information about me needed to determine the payments for services. I understand that:

- Ohio Ophthalmology will have to share my medical record information with my insurance company.
- I must pay my share of the costs including but not limited to copay, coinsurance and deductible.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
- I am responsible for referrals and authorizations required by my insurance for all services.

Release of Information:
I give my permission to Ohio Ophthalmology to release medical records and/or any medical information necessary in order to process applications for financial coverage for services rendered during my visit. The information may be released to third party payers and their agents or to any employer to the extent such release is necessary to secure payment. The release of information may include diagnosis and treatment, including, but not limited to, drug and/or Alcohol Abuse, Mental and Physical Condition, Communicable Diseases, HIV Test Results, AIDS/ARC diagnosis, and any other information requested to determine coverage, medical necessity, or other benefits determination. To enable continuity of care, Ohio Ophthalmology Inc. is authorized to release medical records/or medical information to physicians providing such care.

Revocation:
I understand and agree that this consent will be effective from the date of my signature and remain valid unless revoked by me in written form. I also understand that:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my physician.

By signing below I agree that I have read this consent form carefully and I agree that everything in this agreement applies to current and future health care services provided by Ohio Ophthalmology.

_____ _____ _____
Patient's Signature (or responsible party if the patient is a minor or unable to sign) Date Time

_____Printed name of person signing above Relationship to patient-if the patient isn't signing

_____ _____ _____ _____
Witness signature (**required)** Printed name of witness Date Time