Eye Surgeons Associates

Consent for Medical Treatment, Release of Information & Assignment of Benefits

1. **Consent for Health Care Services:** I am voluntarily seeking health care services at M.H. Peracha, M.D., P.C. dba Eye Surgeons Associates and hereby consent to medical treatment including the administration of medication, dilating eye drops, diagnostic services, and other health care services. I understand that I have the right to refuse specific treatment or procedures that may be recommended by the treating provider. I am over 18 years of age, an emancipated minor, or the parent/legal guardian of a minor under 18 years of age.
2. **Photography:** I consent to the taking of pictures to be used only for the diagnosis and treatment (medical or surgical) of my medical condition.
3. **Authorization for Release of Information:** M.H. Peracha, M.D.,P.C. dba Eye Surgeons Associates may disclose any or all information from my medical records to any health care provider involved in my care and/or treatment. M.H. Peracha, M.D.,P.C. dba Eye Surgeons Associates may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I understand the information to be disclosed may include information relating to alcohol or drug abuse, mental health services, communicable disease or human immunodeficiency virus (HIV). I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, M.H. Peracha, M.D.,P.C. dba Eye Surgeons Associates is no longer responsible for the confidentiality of any information known or possessed by the payer.
4. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided me by the providers of M.H. Peracha M.D.,P.C. dba Eye Surgeons Associates which are not paid by my health insurance or other payer. I understand that I am financially responsible for any and all non-covered charges including co-payments as required by my health insurance plan, deductibles, or services that may be determined as non-covered. Any other charges are due and payable when I receive the statement. If payment is not made within 90 days from the date the first bill was mailed, I understand that I may be charged and liable for a delinquent account fee of the outstanding balance. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with the practice. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.
5. **Pre-authorization Requirements:** I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for benefits for services provided by M.H. Peracha, M.D., P.C. dba Eye Surgeons Associates.
6. **Assignment for Direct Payment:** I authorize that payment of any insurance (including Medicare, auto insurance, worker's comp insurance or other health-care insurance) benefits for health care services or goods may be made directly to M.H. Peracha, M.D., P.C. dba Eye Surgeons Associates.
7. **Missed Appointment Fees:** Effective November 2014, we will charge a missed appointment fee if you fail to cancel your appointment with less than 24 hours advance notice. This fee is the patient/guarantor responsibility and is not covered by insurance. We may require prepayment of any outstanding balances prior to scheduling your next appointment.
8. **Right to Revoke:** I may revoke this agreement at anytime by submitting a written notification to M.H. Peracha, M.D., P.C. dba Eye Surgeons Associates and is valid until revoked or until minor reaches 18 years of age.

I acknowledge that:

- **I have read this form and understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or co-payment that is due at the time of service.**
- **I have received a copy of M.H. Peracha, M.D., P.C., dba Eye Surgeons Associates Financial Policy effective 9/30/2013.**

_____ _____

Signature of Patient or Legally Responsible Person | Name (Please print)

_____ _____

Relationship/Reason Why Patient Is Unable to Sign | Date