Solomon Eye Associates

CONSENT TO TREATMENT: I do hereby voluntarily consent to examination and treatment by SOLOMON EYE ASSOCIATES, PC (the "Practice") and to the rendering of such care and medical treatment as may be deemed necessary or appropriate by the physicians and other clinical personnel of the Practice. I further consent to and understand that my eyes may be dilated. I understand that dilation may cause bright and blurry vision for several hours after my visit. I also understand the risks of declining photos and dilation in regards to my ocular health. I will not hold the Practice or its employees liable for any unintentional problems that result from my exam or follow-up visits.

NO GUARANTEE: I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me or otherwise implied regarding the results of my treatment or examination by this Practice.

RELEASE OF INFORMATION: I hereby authorize the Practice to use or disclose my health information (1) for treatment purposes, (2) in connection with payment or reimbursement for health care services or materials provided to me, or (3) for the purpose of carrying out Practice operations. Such disclosures may be made to any person, company or agency which is or may be responsible for all or a part of the charges for my treatment and/or examination, including but not limited to insurance companies, workers compensation carriers, peer review organizations, government agencies or other responsible parties, all or part of my medical information and records in connection with payment for or establishing the medical necessity of my admission or treatment, or as may otherwise be required by law. I also authorize the release of such information to other treating or consulting physician(s) as who may be involved in my care. In connection with the use of disclosure of my medical information, I acknowledge that the Practice has offered me a NOTICE OF INFORMATION PRACTICES ("NOTICE") that explains how it anticipates use and disclosure of my medical information and I have had an opportunity to review this Notice. I understand that the Practice reserves the right to change the privacy practices set forth in this notice, but if changes are made, will mail me a copy of such changes to my last address. I understand that I have the right to request how the Practice uses or discloses my medical information, but that the Practice is not required to agree to any requested restriction. If the Practice does agree to any requested restriction, I understand that it must abide by that agreement. I further understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice has already taken action in reliance on my consent previous to my revocation. **I authorize the release of information about previous exams from other providers to Solomon Eye Associates, PC.**

ASSIGNMENT OF BENEFITS: In consideration of medical services to be rendered to me or at my request, I assign to the Practice to the extent necessary to satisfy any outstanding indebtedness, all sums payable to or on my behalf pursuant to any health benefit plan, policy of insurance (including, but not limited to, health, liability, uninsured motorist or medical payments insurance) and/or pursuant to any settlement or judgment arising out of or related to any incident which caused the need for treatment. I also authorize my insurance provider to make payments on my behalf to the Practice.

FINANCIAL RESPONSIBILITY: In consideration of medical services to be rendered to me or at my request, I understand that I owe, and unconditionally agree and promise to pay, the Practice the full amount charged for these services, due at the time of service. I specifically agree to pay for any services which are determined by any health benefit plan or insurance company not to be covered (including, but not limited to, contact lens evaluation fees, contact lens supplies, retinal photography, or refraction). I understand that I am responsible for any deductibles, co-payments and/or non-covered services. I understand that any check for services that is returned for any reason, will result in a fee of $25 which will be added to my account. I understand that there will be a 5% monthly finance charge added to my account if it is not paid within 30 days. I further understand that if my account is not paid within sixty (60) days, it may be declared in default and placed in the hands of a collection attorney. I agree to pay an additional fee of thirty-five percent (35%) of the unpaid balance on my patient account to cover attorney's fees should I default on my debt.

MEDICARE PATIENTS: I request payment of authorized Medicare, Medicaid and Tricare (Champus) benefits, if any, for any services furnished to me by the Practice and hereby assign such benefits otherwise directly payable to me to the Practice. I authorize the Practice or physician(s) providing services to submit a claim for such services to Medicare, Medicaid or Tricare (Champus) on my behalf. I authorize the Practice or any holder of medical and other information about me to release to Medicare, Medicaid, Tricare (Champus) or its agents any information needed to determine these benefits. I understand that I am responsible for any deductibles, co-payments and/or non-covered services as defined by Medicare, Medicaid or Tricare (Champus).

COMANAGEMENT: It is my desire to have Dr. Michelle Solomon perform any postoperative follow-up care after cataract surgery or other ophthalmology care. I understand that I may elect to have my optometrist perform my postoperative follow-up care for any personal reasons, including but not limited to comfort, convenience, familiarity, and transportation. I understand that as a result of my decision, my optometrist will receive that portion of the surgical fee designated for delivery of postoperative care. I have discussed this post-operative selection with my optometrist and with my ophthalmologist. My ophthalmologist has informed me that an optometrist may lawfully provide post-operative care under applicable state law. I understand that my optometrist will contact my ophthalmologist immediately if I experience any complications related to my eye surgery. I understand that I may also contact my ophthalmologist at any time after the surgery.
Ophthalmologist name (if known): _____.

CONTACT LENSES: I understand that contact lenses are medical devices for the eye and they are very helpful when used properly. If they are not used responsibly, they may cause problems such as discomfort, infection, or vision loss. I agree to wear my lenses responsibly as prescribed by the doctor. I voluntarily seek a contact lens evaluation and I will not hold Solomon Eye Associates, PC or its employees responsible for any problems associated with contact lens wear.

CONTENT OF FORM: I have read the information provided in this form (or had such information read to me) carefully and in its entirety, have been given an opportunity to ask questions and have received satisfactory answers to my questions. I understand the content of this form and agree to the terms contained herein. I certify that all information supplied by me as part of the patient registration process is correct.

X _____ _____ _____ _____

Patient or Patient Representative Date Witness Date

_____

(If being signed by Patient Representative, please indicate relationship to patient)

OPTOMETRIST CONFIRMATION (for cataract patients): I have agreed to be fully responsible for providing follow-up care for the above-named patient. I will see the patient after surgery when the ophthalmologist notifies me that the patient is released to my care. I agree to notify the ophthalmologist immediately should complications arise and to maintain written progress reports during my portion of the postoperative period.

X _____

Michelle Solomon, OD