Georgetown Vision Center

Consent to Treat: I have requested medical services from Georgetown Vision Center on behalf of myself and/or my dependents. I agree to and understand that my Doctor may request that my eyes be dilated as part of a comprehensive eye exam. I understand that if my pupils are dilated, I may not be able to safely operate a motor vehicle and that the staff and doctors of Georgetown Vision center request that I arrange alternate transportation.

Payment and Financial Information: Payment is due at the time services are rendered. Accepted methods of payment are cash, check, or credit card. Accounts that become delinquent may be referred to a collection agency, and you are responsible for collection costs in addition to your outstanding balance. There is also a $30.00 fee for checks returned by the bank.

Acknowledgement of Privacy Practices and Policies: I have been made aware of and/or reviewed this office's Notice of Privacy Practices, which explains how my medical information may be used or disclosed. I understand that I am entitled to receive a copy of this document upon request.

Cancellation Policy: We require 24 hours of notice to cancel or reschedule your appointment. This time has been reserved for you and will be billed as a missed appointment if proper notice is not given. Future appointments will require a $50 deposit.

Insurance Information: Please provide insurance information prior to your appointment, and present ALL insurance cards at the Front Desk during check in. Georgetown Vision Center will bill those plans for which we have an agreement and will require you to pay the authorized co-payment/co-insurance at the time of service. If it is determined that you do not have benefits to cover today's visit, you have been seen out of network, or your insurance determines that services are not covered, please understand that **you are responsible for payment of today's services.**

I certify that the insurance information that I have given is correct, and I authorize Georgetown Vision Center to act as my agent in helping to obtain payment for services and materials furnished including the release of any information necessary to insurance carriers regarding my diagnosis and treatments to process the claims. This order will remain in effect until revoked by me in writing.

Authorization for Release of Identifying Health Information: If you are 18 years or older and you want another person or family member to have access to your medical records, account information, or prescription, please indicate by providing details below.

I _____, authorize Georgetown Vision Center to release health information about me including the personal health, account, and insurance information in my records to the following:

_____relationship_____phone_____

_____relationship_____phone_____

I certify with my signature below that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Responsible Party

/s/_____Date:_____