

**Consent for release of information to the below listed parties
for payment and/or insurance benefit-claims purposes;
Responsibility for Payment Notification**

- I consent to the use and disclosure by the Office and any information, e.g. health information concerning my vision examinations and products, to any party and/or agent, including, but not limited to my employer, health plan or plan sponsor ("Plan"), as needed for my treatment, the payment of my vision benefit claims, and related customer communications regarding health care services provided by the Office (e.g. mailings of appointment reminder or recall cards, billing and payment collections, or explanations of services/products provided by the Office).
- If I desire to seek third party reimbursement for the services received, I authorize the Office to submit a vision benefit claim for payment to any third party as identified. I understand that I am responsible for all charges incurred, including any portion not paid by any/all third party(s).
- I understand that this consent for release of information is voluntary and I may revoke my consent at any time by notifying the Office in writing except for any disclosure already taken in reliance of my consent to release information. I understand that I may request the Office to restrict the use and disclosure of my information; however, the Office is not required to agree to my request unless my request is submitted in writing. Should I choose to revoke this consent, I understand that I am responsible for any/all charges billed to my account regardless of my third party/insurance claim status.
- I understand that any charges billed to me are due at the time of service unless other payment arrangements have been made. I understand that all charges billed to any minor children in my dependency are my responsibility. I understand that should I fail to meet my payment obligations the following may/will occur at the discretion of the office: a monthly finance charge of 1.5% - 18% annually (\$1.00 minimum) on any balance due will be billed to me; should my account fall 90 days or more past due or should at anytime my account be processed for Non-Sufficient Funds (NSFs); I will be subject to collections proceedings at the discretion of the office.

Patient's Name

Date of Birth (MM/DD/YYYY)

Signed (Patient or Legal Representative for Patient)

Date

Legal Representative's Relationship to Patient