**AUTHORIZATION**

**GENERAL CONSENT TO TREATMENT:**

I agree and consent to a physical examination by the patient’s physician(s). I understand that additional diagnostic procedures and treatment may be recommended by the physician(s) and will be discussed with me before being done. I acknowledge that there are no guarantees expressed or implied as to the results of any procedures or medical treatment.

**RELEASE OF INFORMATION:**

I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse and HIV status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid (or their various intermediaries), as well as the insurance company, health maintenance organization, an employer, any person acting on behalf of a preferred provider arrangement or third party named on this patient information form (or any of their agents or representatives) when such information is requested for payment, worker’s compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician’s office.

**ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE:**

I authorize any third party payer to pay directly to the physicians providing services to the patient, all benefits due and payable as a result of service rendered.

I authorize assignment to the physician who has provided services to the patient the insured’s rights to penalties and attorney’s fees in the event that the insurer fails to timely pay such benefits in accordance with Louisiana Law (LA. R. S. 22:657).

**ACKNOWLEDGEMENT OF RESPONSIBILITY TO PAY FOR SERVICES:**

I understand that the physicians will, as a courtesy, file claims with insurance carriers and third party payers. I acknowledge and agree that except as provided by law and in consideration of the services provided, I will pay any charges that are not paid by a third party payer. In the event my account is turned over to a collection agency, I will be responsible for any and all additional fees incurred. These additional fees may include attorney fees, court cost, and/or any other incidental expenses.

**MEDICARE PATIENTS:**

I request that payments of authorized Medicare benefits by made on my behalf to **Casanova Eye Care** for any services furnished to me by that provider.

I authorize any holder of my medical information may release that information in order to determine benefits payable for related services to Health Care Financing Administration and its agents.

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 PATIENT’S SIGNATURE (PARENT FOR MINOR) DATE