

CONSENT FORMS

WHO IS RESPONSIBLE FOR PAYMENT?

SELF: _____ IF SOMEONE ELSE, WHO? _____
NAME: _____ RELATIONSHIP TO YOU: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

Assignment and Release: I hereby authorize my insurance benefits be paid directly to Greenbush Eye Center and I acknowledge that I am financially responsible for any unpaid balance. I also authorize Greenbush Eye Center to release any information required to process said claims.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. I FURTHER UNDERSTAND IF I HAVE INSURANCE AND DO NOT INFORM YOU OF IT TODAY, THERE WILL BE A \$25 SERVICE FEE TO PROCESS A CLAIM AFTER THE DATE OF SERVICE.

All eyeglass orders are final. Since prescription eyewear is a custom-made product that is ordered within 24 hours if not on the same day of service, once it is ordered it cannot be canceled or refunded. It can be exchanged for a different product or an office credit will be issued.

Date:

Patient/Guardian Signature:

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Greenbush Eye Center's, Notice of Privacy Practices.

Date _____ Patient name _____ Signature _____

In addition to the usual entities, I authorize Greenbush Eye Center to disclose my health information to the following parties (this authorization shall remain in affect until we receive notice in writing from you of any changes):

Date: _____ Patient name: _____ Signature: _____