Davis Eye Care
110 College St., Suite B
Athens, AL 35611
(256) 233-2393

Patient Name:

Account #

**Consent for Medical Treatment, Release of Information, Privacy Notice, and Guarantee of Payment**

1. **Consent of Treatment**: I consent to necessary treatment including drugs, medicine, performance of in-office procedures, or other studies and tests that may be used by the doctors and staff.
2. **Authorization for Release of Information and Privacy Statement Notice**: Davis Eye Care may release information from my medical records to any health care provider involved in my care and treatment. Davis Eye Care may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, workers' compensation carrier or my employer who is providing payment due to injury on the job. I have received notice that Davis Eye Care abides by HIPAA privacy policy.
3. **FINANCIAL AGREEMENT**: I understand that I am responsible for all charges at time of service and that there is no guarantee of payment from any insurance company or other payer. I understand that some routine services are not covered by my insurance and that I am financially responsible for all charges at time of service. I agree to pay all charges for the services provided by Davis Eye Care which are not paid by my health insurance or other payer. I authorize Davis Eye Care to keep my signature on file and to charge my credit card or bank account on record for all remaining balances after insurance claims is/are resolved. This includes co-pays, deductibles, glasses, contact lenses, and any denied claims. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that I am responsible for a $25 returned check fee in addition to any other associated bank charges for denied payment.
4. **GUARANTEE OF PAYMENT OF ACCOUNT**: I authorize Davis Eye Care to keep my signature on file and to charge my credit card or bank account on record for all remaining balances after insurance claims is/are resolved. This includes co-pays, deductibles, glasses, contact lenses, and any denied claims.
5. **Assignment of Insurance Benefits**: I hereby assign and request that payment of all insurance benefits be made directly to Davis Eye Care. Furthermore, I understand that I am financially responsible for any and all charges incurred while under care of this office.

**Signature of Patient or Legally Responsible Party** **Date**

**Relationship/Reason why Patient is Unable to Sign**