PLEASE COMPLETE AND SIGN WHERE INDICATED AT THE 5 ARROWS ➡
EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION)

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF TO DESOTO EYE CARE FOR ANY SERVICES FURNISHED ME BY THAT PROVIDER.

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS AND/OR OTHER INSURANCE COMPANIES SAID INFORMATION NECESSARY TO DETERMINE BENEFITS PAYABLE FOR RELATED SERVICES.

I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS (MEDICARE/MEDICAID) EITHER TO MYSELF OR TO DESOTO EYE CARE SHOULD THEY AGREE TO ACCEPT THE ASSIGNMENT OF THESE BENEFITS.

THIS AUTHORIZATION MAY BE CANCELLED AT ANY TIME BY CONTACTING OUR OFFICE AND SENDING A WRITTEN REQUEST.

I UNDERSTAND THAT DESOTO EYE CARE WILL ASSIST IN FILING INSURANCE FORMS, BUT THAT I ACCEPT PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL OUT-OF-POCKET EXPENSES INCLUDING NON-COVERED SERVICES WHICH MAY INCLUDE REFRACTIONS, ROUTINE EYE EXAMS, CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE, ETC. IT IS MY RESPONSIBILITY TO KNOW WHICH HOSPITALS AND LABS ARE IN MY INSURANCE PLAN.

IN THE EVENT THAT SERVICES OF AN ATTORNEY ARE REQUIRED TO COLLECT THESE CHARGES, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ANY ATTORNEY'S FEES OR COURT COSTS INVOLVED.

_____ _____

➡ PATIENT/GUARDIAN SIGNATURE DATE

PARTICIPATING HOSPITALS _____

PARTICIPATING LABS _____

PLEASE LIST THE FAMILY MEMBERS OR OTHER PERSONS, IF ANY, WHOM WE MAY INFORM ABOUT YOUR GENERAL MEDICAL CONDITION AND YOUR DIAGNOSIS:

_____

_____

PLEASE PRINT THE ADDRESS OF WHERE YOU WOULD LIKE YOUR BILLING STATEMENTS AND/OR CORRESPONDENCE FROM OUR OFFICE TO BE SENT IF OTHER THAN YOUR HOME.

_____

CAN WE SEND A POSTCARD REMINDER CARD OF YOUR APPOINTMENT?

_ YES. A POST CARD IS FINE. _ NO. PLEASE SEAL IN AN ENVELOPE AND MARK CONFIDENTIAL

CAN WE FAX MEDICAL INFORMATION? _ YES _ NO

CAN CONFIDENTIAL MESSAGES (I.E. APPOINTMENT REMINDERS) BE LEFT ON YOUR HOME ANSWERING MACHINE OR VOICEMAIL?

_ YES _ NO

IF YOU DO NOT HAVE VOICEMAIL, CAN A CONFIDENTIAL MESSAGE BE LEFT AT YOUR PLACE OF EMPLOYMENT? _ YES _ NO

_____ _____

➡ PATIENT/GUARDIAN SIGNATURE DATE

AN ADMINISTRATIVE FEE OF **$10.00** WILL BE CHARGED IF YOU DO NOT PAY YOUR CO-PAY AT THE TIME OF SERVICE.
A FEE OF **$10.00 - $25.00** FOR FORM COMPLETION (DISABILITY, FMLA, ETC.) WILL BE CHARGED DEPENDING ON THE COMPLEXITY OF THE FORM.

_____ _____

➡ PATIENT/GUARDIAN SIGNATURE DATE

I HEREBY GRANT MY PERMISSION FOR RELEASE OF MY MEDICAL RECORDS TO ANY PHYSICIAN THIS OFFICE DEEMS NECESSARY FOR THE TREATMENT OF MY CONDITION. THIS WILL INCLUDE, BUT IS NOT LIMITED TO MY REFERRING PHYSICIAN AND MY PRIMARY CARE PHYSICIAN. IN THE EVENT DESOTO EYE CARE FINDS IT NECESSARY TO CONSULT WITH ANOTHER PHYSICIAN REGARDING MY CARE, I HEREBY GRANT PERMISSION FOR CONSULTATION.

_____ _____

➡ PATIENT/GUARDIAN SIGNATURE DATE

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPAA – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT). THIS DOCUMENT ALSO INCLUDES MY RIGHTS AS A PATIENT.

___ I ACCEPT THE TERMS OF THE PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION FOR DESOTO EYE CARE.

___ I DECLINE THE TERMS OF THE PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION FOR DESOTO EYE CARE.

_____ _____

➡ PATIENT/GUARDIAN SIGNATURE DATE