## DR. DAWN RAKICH, OPTOMETRIST
## INFORMED CONSENT & TREATMENT AUTHORIZATION

The law requires that we make every effort to inform you of your rights related to your personal health information.

- I (do) ____ (do not) ____ authorize Dr. Dawn Rakich, Optometrist or her staff to leave a message with available persons at my home phone number, on my answering machine or with the emergency contact listed above.
- I (do) ____ (do not) ____ authorize Dr. Dawn Rakich, Optometrist or her staff to leave a message at my place of employment.

I hereby authorize Dr. Dawn Rakich, Optometrist to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care. I have read & understand the above information & am signing this form voluntarily.

_____ _____

**Patient or Legal Guardian's Signature** **Date**

### FINANCIAL & INSURANCE FILING POLICY

- *All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or copay*
- *If your insurance company does not pay your claim within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, you are responsible for payment.*
- *If your insurance company does not pay within 45 days, we will require you to pay the balance by cash, check, money order, Visa or Mastercard.*
- *Payment for copay and/or deductible is due at the time services are rendered.*
- *We accept cash, checks, money orders, Visa and Mastercard.*
- *Canceled or rescheduled appointments are subject to a fee if we do not receive 24 hours advance notice.*
- *In the event that refraction is not covered by your insurance you will be charged a fee in addition to your copay and/or deductible.*

### AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS

I _____, authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to Dr. Dawn Rakich, Optometrist. I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to Dr. Dawn Rakich, Optometrist for any services furnished to me by Dr. Dawn Rakich, Optometrist. I authorize any holder of medical information related to me to release to the Centers for Medicare & its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made & authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, & the patient is responsible only for the deductible, copay, & non-covered services. Copay & deductible are based upon the charge determination of the Medicare carrier. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any & all legal fees, court costs, & collection charges. There will be a service charge for each returned check. This authorization & assignment will remain in effect until revoked by me in writing. A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to & completed all of the conditions listed above. I accept financial responsibility for all charges. I have read & understood this information & I am signing voluntarily.

_____ _____

**Patient or Legal Guardian's Signature** **Date**