Patient Responsibility Agreement

Patient Name: _____
Date of Birth: _____
Appointment Date: _____

1. Insurance Information and Coverage

I understand that it is my responsibility to provide accurate and current insurance information at the time of my appointment. I acknowledge that my insurance policy is a contract between me and my insurance company, and that it is my responsibility to understand the coverage and benefits provided by my policy.

2. Payment for Services

I agree to pay for any services provided by Aesthetic Eye Care that are not covered by my insurance plan. This includes copayments, deductibles, coinsurance, and any other charges that my insurance company determines are my responsibility.

3. Financial Responsibility

I understand that I am financially responsible for all charges related to my eye care services. If my insurance company denies payment or only partially covers the cost of services, I agree to pay the remaining balance.

4. Collection Fees

I acknowledge that if my account becomes delinquent and is sent to a collection agency, I will be responsible for any collection fees, attorney fees, and court costs incurred in the process of collecting the outstanding balance.

Patient Signature: _____
Date: _____

Guardian/Responsible Party (if applicable): _____

Date: _____

Consent to Treatment Form

Patient Name: _____
Date of Birth: _____
Appointment Date: _____

Consent to Examination and Treatment

I hereby authorize Aesthetic Eye Care and their designated assistants to perform comprehensive eye examinations, diagnostic tests, and treatments as deemed necessary based on the findings of the examination. I understand that these procedures may include, but are not limited to, visual acuity tests, refraction, pupil dilation, and intraocular pressure measurement.

Patient Signature: _____
Date: _____

Guardian/Responsible Party (if applicable): _____
Date: _____

Release of Medical Records

To: Custodian of Medical records. This authorizes you to release to Aesthetic Eye Care full and complete medical records, reports, evaluations, consultations, or information (collectively referred to as “medical records”) you may have in custody concerning the undersigned patient. The undersigned represents and warrants that they have full authority to request said records and to agree to all the conditions recited herein. The undersigned expressly released and forever discharges and agrees to indemnify and hold harmless Aesthetic Eye Care including its owner and employees, from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising out of or from the release of any medical records pursuant to this authorization.

Patient Signature: _____
Date: _____

Guardian/Responsible Party (if applicable): _____
Date: _____

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____
Date of Birth: _____
Appointment Date: _____

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a patient rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgment. The terms of our Notice may change, and if we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Aesthetic Eye Care. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient Signature: _____
Date: _____

Guardian/Responsible Party (if applicable): _____
Date: _____