Patient Consent Form

Name: ____ Date of Birth: ___________________
(Please Print Last and First Name)

Financial Responsibility & Assignment of Benefits

I understand that insurance billing is provided as a courtesy and that I am financially responsible to Foothill Eye Care Services (FECS) for all charges arising from my treatment. It is my responsibility to notify FECS of any changes in my health care coverage. While FECS verifies my insurance eligibility, exact insurance benefits cannot be determined until the health plan receives the claim. I agree to accept financial responsibility for all medical services or supplies receive by me.

I understand that all copayments, co-insurances, deductibles, and balances will be collected prior to any services being rendered. I also am aware that FECS is obligated by contract not to bill any copayments.

I authorize direct payment from my health insurance plan to FECS for all services and supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer.

Cancellation Policy

We understand that circumstances may arise requiring you to cancel your scheduled appointment.
Please try to give us a 24 hour cancellation notice.

Consent for Treatment and Release of Information

I am aware of my diagnosis and wish to receive treatment from FECS. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Foothill Eye Care Services to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided. I authorize FECS to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment. I certify that I have read this agreement and my signature indicates my understanding and consent.

Signature____ Date______________