University Eye Center of the State University of New York College of Optometry **MRN#** _____

Consent for Examination and Treatment

Patient Name_____: In seeking appropriate and medically necessary eye care services, I voluntarily consent to such care including routine diagnostic and therapeutic procedures and medical treatment to be provided by the clinical and professional staff of the University Eye Center (UEC). I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in this center. This consent has been fully explained to me and I certify that I understand its contents.

I authorize the UEC to retain, for scientific or educational purposes, or to otherwise utilize, photographs, videotape or other images or clinical information from the procedure, examination or treatment consistent with College policies and HIPAA regulations for patient privacy protection and research.

_____	_____
Signature of Patient/ Relative/Legal Guardian Date	Witness Signature* Date
If relative or legal guardian signs, indicate relationship:_____	*The witness must be someone other than the practitioner obtaining the consent. The witness is attesting only to the fact that the patient or other appropriate person has signed the form.

Research OPT-Out

☐ I DO NOT wish to be contacted regarding potential research studies. _____ Patients Initials

Advanced Directives

Do you have an advanced directive? Yes No

Explain: _____

_____

Acknowledgement of Receipt

By initialing below, I acknowledge that I have been provided with a copy of:

-The Notice of Privacy Practices which details how certain health information about me may be used and disclosed by the UEC of the State University of New York, College of Optometry and how I may obtain access to and control this information;

-Patient bill of rights and grievance procedures;

and,

-UEC Insurance and payment policies. **Patient Initials**_____

Signature on File / Payment Authorization

I request that payment for all services rendered by this facility be made on my behalf to the University Eye Center (UEC). I authorize the UEC to release to the Centers for Medicare and Medicaid (CMS) and its agents or any other insurer any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that my signature will serve as a lifetime authorization for the release of medical information necessary to pay the claim. If another insurer is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

I also understand that:

- If my insurance company requires a referral/authorization which is not available at the time of service, I will be financially responsible for the entire charge for the services rendered.
- I am responsible for all charges not covered by my insurance benefits, including the refraction charge.
- I have been given a copy of the UEC's insurance and payment policies and agree to abide by these policies.

Signature_____Date_____