Tarboro Eye Associates

GENERAL CONSENT TO TREAT

PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by the Tarboro Eye Associates for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by the Tarboro Eye Associates and its associated physicians, clinicians, and other personnel for myself or for the undersigned patient for whom I am the guarantor. I/we am/are aware that the practice of medicine is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATIONS FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning, and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

Promise to Pay: ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for an account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and the Tarboro Eye Associates. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand the Tarboro Eye Associates can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection I/we shall pay all collection fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FROM

I understand that North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Worker's Compensation Commission pursuant to NC General Statutes ş 97-27.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I/we have received a copy of the Notice of Privacy Practice. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.tarboroeye.com

I understand this facility participates in an electronic health information exchange. This exchange program provides a fast, secure, and reliable way to provide health information to other providers. I understand my electronic health records may be shared with other providers who are involved in my care. I understand a provider may also request and receive my information using other methods permitted by law, such as fax or mail.

I understand that if I have paid entirely out-of-pocket for this medical visit that I may ask the Tarboro Eye Associates not to share related information about the visit with my health Insurer by completing a "Patient Request for Restriction" form. By checking below, I am asking the Tarboro Eye Associates not to share information about my visit with my health Insurer, and that I am agreeing that I will pay all expenses related to this visit within ten (10) days of receiving services. I understand and agree that if I fail to pay all related charges within 10 days the Facility may share my information with my health insurer.

_____ _____

Date and Time Signature of Patient or Parent, Guardian, or Legally Authorized Representative

_____ _____

Clinic Witness Signature of Guarantor (Relationship to Patient)

Chart#_____ Patient Name _____