

We need your signature on the following statement so that we may submit your charge to **MEDICARE:**

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Moore Eye Care, P.C. for any services furnished to me by that supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

MEDICARE BENEFICIARY SIGNATURE _____

DATE _____

We need your signature on the following statement so that we may submit your charge to your COMMERCIAL INSURANCE:

I authorize any holder of medical information about me to release this information to my insurance company, its intermediaries, or carriers, to my attorney, or to another physician's office.

I hereby authorize direct payment of medical and or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Moore Eye Care. I understand that, as these services were performed for me, I am financially responsible for all charges, whether or not paid by insurance.

PATIENT OR RESPONSIBLE PARTY'S SIGNATURE _____

DATE _____

CONSENT FOR DILATING EYE DROPS AND PRESSURE MEASUREMENTS

Dilating eye drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person, and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, you should not drive yourself. I hereby release the practice from any liability. In the course of examining you or taking your eye pressure, on occasion, a scratch can occur in the eye. Please call us IMMEDIATELY after your visit if you have pain, since this can lead to corneal ulcer and possible loss of vision. This occurs very rarely. I hereby agree to allow the staff of Moore Eye Care to take my eye pressure and release the practice from any liability.

PATIENTS SIGNATURE _____ DATE _____

MOORE EYE INSTITUTE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

*I have received a paper copy of Moore Eye Institute's
Notice of Privacy Practices.*

Name: _____

Signature: _____

Date: _____

MOORE EYE INSTITUTE

Authorization for the Use/Disclosure of Protected Health Information (PHI)

I authorize Moore Eye Institute to disclose my protected health information to:

Name: _____

Address: _____

City _____ State _____ Zip _____

The protected health information to be used or disclosed is as follows: (Please check off all that apply or record other information in the space provided.)

- Entire Medical Record
- Medication List
- Laboratory results from _____ to _____ (dates)
- X-ray or other imaging reports from _____ to _____
- Office notes from _____ to _____
- Other information (please describe)

This information is being used/disclosed for the following purpose:

- At my request
- Other _____

I understand that I have the right to revoke this authorization, in writing, at any time giving notice of my revocation to the Privacy Officer, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on _____.

I understand that information disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. The covered entity may not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization except (1) if my treatment is related to research, or (2) if healthcare services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Print name

Date of birth

Signature of Patient or Personal Rep.

Date