Aurora
EYE CLINIC

PATIENT ACKNOWLEDGEMENTS

DILATION: I acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred 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, it may be best if you make arrangements not to drive yourself. Please ask for assistance if your vision is markedly affected.

Initials: _____

Financial Assignment: I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Aurora Eye Clinic for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

Initials: _____

Financial Responsibility: I understand that I am financially responsible for the timely payment of all charges not covered by insurance. Unless I make prior arrangements, I will pay "out of pocket" charges on the day of service. Medical insurances (including Medicare) do not pay for the examination required for glasses (ie refraction). I understand I am responsible for payment. I understand that HMO insurance requires a referral and/or prior approval for treatment. I am aware that if a referral/authorization is not present at the time of treatment, that I am aware that I am financially responsible for treatment.

Initials: _____

Release of medical Information: I agree to the release of my medical information to my primary care physician(s) and/or optometrist(s).

Initials: _____

Communications: I authorize Aurora Eye Clinic to communicate with me by phone, answering machine/voice mail, letter or email at home or business regarding appointments, care or billing.

Initials: _____

Notice of Privacy Practices: I acknowledge that a copy of Aurora Eye Clinic's Notice of Privacy Practices has been provided to me for review and a copy is available at my request.

Initials: _____

Patient Name _____ **Date** _____

Signature (Patient/Legal Guardian) _____ **Legal Guardian Name *(if applicable)*** _____