TEXAS EYE PHYSICIANS, PA
HUY M. TRAN, M.D.

DIPLOMATE OF THE AMERICAN BOARD OF OPHTHALMOLOGY
FELLOW OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

101 WEST RANDOL MILL ROAD STE 120 ARLINGTON, TX 76011
WWW.TEXASEYEPHYSICIANS.COM
TELEPHONE (817) 861-3937 FACSIMILE (817) 861-3914

PLEASE READ AND SIGN BELOW:

I acknowledge I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

I hereby authorize the physician and staff of Texas Eye Physicians, PA (TEP) to perform procedures necessary to assess and diagnose my condition properly, and such treatments as may be prescribed by my attending physician during any and all visits to TEP.

I understand that I am financially responsible to all charges arising from services rendered to me by TEP and hereby agree to pay the established charges for services and all other charges incurred as a patient of TEP or Dr. Huy M. Tran.

I hereby authorize payment directly to TEP, or Dr. Huy M. Tran, the group Hospital Benefits or Insurance Benefits, including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for the services rendered. I understand that I am financially responsible to TEP for charges not covered by this authorization.

I will cooperate in seeking, collecting and paying to TEP all insurance proceeds. If the insurance proceeds cannot be paid directly to TEP, I agree to collect payment and pay to TEP within five (5) days of receipt.

I hereby authorize TEP to release any information concerning my care for purposes of claims to Federal, State, City or Town Governmental Agencies or third party payors (insurance companies) of all categories, doctors and hospitals.

I permit a copy of this authorization to be used in place of the original.

*Signature of Patient:*_____*Date:*_____

OR

*Other Responsible Person:*_____*Date:*_____