Lori J. Clark O. D., Inc., An Optometric Corporation

Consent to Medical Treatment

I consent and authorize Lori J. Clark O. D., Inc., An Optometric Corporation and its agents to administer any treatment which may be reasonable or necessary for diagnosis and treatment of myself or my family members. I give Dr. Clark permission to follow up with me on any condition for which I have been previously diagnosed.

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize Lori J. Clark O. D., Inc., An Optometric Corporation to act as my agent in helping me to obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Lori J. Clark O. D., Inc., An Optometric Corporation for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS–1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Financial Responsibility

By signing this statement, I agree to be financially responsible for all charges, regardless of any third party coverage I may have. Professional fees are due when services are rendered and a 50% deposit is due when materials are ordered. Full payment is due at the time of dispensing of materials unless other arrangements have been made. Any check returned by the bank will incur a $25 dollar charge. Overdue accounts maybe referred to an outside agency for collection, and I will be responsible for all collection and attorney's fees.

HIPAA Acknowledgment

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice Of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice Of Privacy Practices from Lori J. Clark O. D., Inc., An Optometric Corporation.

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Patient/Guardian Signature Date

_____

Patient Printed Name