PATIENT ACKNOWLEDGEMENT

PATIENT NAME: ____ ID: ______________________________

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Our Patient Rights and Responsibilities describes your rights under the law. You have the right to review our Notices before signing this acknowledgement. By signing this form, you acknowledge that you were provided a copy of the Retinal Consultants of Arizona Notice of Privacy Practices and Patient Rights and Responsibilities. These notices describe the use and disclosure of protected health information about you for treatment, payment, health care operations, and other uses and disclosures as stated. They also describe certain patient entitled rights and certain patient responsibilities to fulfill healthcare needs.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Retinal Consultants of Arizona has a Notice of Privacy Practices and Patient Rights and Responsibilities and the patient has the opportunity to receive a paper copy of these Notices.
- Retinal Consultants of Arizona reserves the right to change the Notice of Privacy Practices and Patient Rights and Responsibilities at any time. A current copy of these notices may be obtained by contacting our office.
- Retinal Consultants of Arizona will also use and share your health information as required/permitted by law.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION UPON REQUEST

I, ___________________________, give my permission to disclose protected health information from my health records, including financial information, to the following person(s).

Name(s): ____

Patient Signature: ____ Date: __________________________

AUTHORIZATION TO ASSIGN BENEFITS AND STATEMENT OF FINANCIAL RESPONSIBILITY

I authorize and request that the payment of Medicare and/or insurance benefits be made directly to Retinal Consultants of Arizona for any and all services provided to me by Retinal Consultants of Arizona. If my health insurance will not allow direct payment to Retinal Consultants of Arizona or if Retinal Consultants of Arizona chooses not to accept assignment of medical benefits, I agree to immediately forward to Retinal Consultants of Arizona any and all health insurance payments I receive. I acknowledge that I am responsible for all charges for services provided by Retinal Consultants of Arizona, including any non-covered services or amounts not paid by insurance. This also applies if coverage is provided by Medicare, a Health Maintenance Organization, a Worker's Compensation policy, or any other third-party payers.

Printed Patient Name: ____

Signature: ____ Date: __________________________

Relationship to patient (if other than patient): ____

GENERAL CONSENT TO TREAT

By signing below, I authorize the health care providers at Retinal Consultants of Arizona, to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care, services or therapies necessary to effectively diagnosis and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo particular procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recuperation, the likelihood of achieving goals, reasonable alternatives, and the relevant risks, benefits, and side effects related to the alternatives, including the possible results of not choosing to undergo the recommended treatment.

I consent to the presence of students, trainees, observers, medical sales representatives, and/or non-facility personnel as deemed necessary and/or appropriate at the discretion of my physician and/or the management of Retinal Consultants of Arizona.

Printed Patient Name: ____

Signature: ____ Date: _____________________________

Relationship to patient (if other than patient): ____