Pediatric Ophthalmology
& Adult Strabismus

UPDATED	

You must provide us your insurance card to copy. If you do not have your card with you, you will be classified as self-paying until you send us a copy of your insurance card.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. Necessary forms will be completed to expediate insurance carrier payments after payment is received from the patient. Copayment is requested at the time of the visit.

THE PATIENT IS RESPONSIBLE FOR FEES, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN: I hereby certify the above named services were rendered and direct payment may be made to the physician named hereon. I am financially responsible for charges not covered by my insurance.

RELEASE: I agree that recognizable photographs and a description of my eye condition may be published in medical journals or be presented to scientific medical groups and will not be altered.

DECLARATION: Our doctors and chief optician declare a financial interest in our eyewear shop - Pediatric Eyewear, Ltc.

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Pediatric Ophthalmology and Strabismus, Inc. for any services furnished me by physician or 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 payable for related services."

Patient's Name_____HIC Number_____

A copy of this signature is as valid as the original.

CONSENT FOR TREATMENT IN THE ABSENCE OF PARENT/GUARDIAN

I hereby give permission and written consent to Pediatric Ophthalmology and Strabismas, Inc, its physicians and employees to render any and all medical treatment as deemed necessary to my child/children listed below, who are minors, in my absence. This permission applies to only the people who are listed below:

1._____

2._____

Parent/Legal Guardian Signature:_____**Date**_____

*****A fee of $25.00 will be charged for missed appointments. *****

REV. 10/09