BUGLISI EYE CARE, PLLC

Consent for Purposes of Treatment, Payment and Healthcare Operations

CONSENT FOR TREATMENT:

The undersigned consents to any examination, laboratory procedure, or other medical treatment or service rendered to the patient under the general and special instructions of Dr. Joseph A. Buglisi, Jr., DO. The undersigned is aware that the practice of medicine and surgery is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. The undersigned has been informed of the patient's right and responsibilities.

RELEASE OF INFORMATION:

The undersigned hereby authorizes this medical office to disclose all or any part of the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of this medical office's charges or having the responsibility for reviewing such charges, including but not limited to this medical office or medical service organizations, health maintenance organizations, insurance companies, workers compensation claims, welfare funds, or peer review organizations. The undersigned agrees to the copying of all medical record(s) which is/are to be sent to a receiving facility in the event that the undersigned must be transferred to another provider/facility. The undersigned acknowledges and consents that medical records, laboratory results, radiology reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

REQUEST FOR PAYMENT, ASSIGMENT OF BENEFITS, AND RELEASE OF INFORMATION FOR MEDICARE/MEDICAID PATIENTS:

The undersigned requests payment of authorized Medicaid/Medicare benefits, if any, for any services furnished to the patient by Buglisi Eye Care, PLLC, including physician services, and hereby assigns such benefits otherwise payable directly to the patient, to Buglisi Eye Care, PLLC, or physician(s) furnishing such services. The undersigned authorizes Buglisi Eye Care, PLLC, or such physician to submit a claim for such services to Medicare/Medicaid. The undersigned authorizes any holder of medical or other information about the patient to release to Medicare/Medicaid, or its agent, claims processor, or utilization reviewers, any information needed to determine these benefits or benefits for related services.

ASSIGNMENT OF INDIVIDUAL BENEFITS:

In the event the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, the undersigned authorizes Buglisi Eye Care, PLLC, or physicians to submit a claim for such services, and benefits are hereby assigned to this medical office for application on the patient's bill. It is agreed that Buglisi Eye Care, PLLC, may receive any such payment and such payment shall discharge the paying insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by the insurance. The undersigned certifies that the patient information given by or on behalf of the patient in applying for payment from all third party payors is correct.

FINANCIAL AGREEMENT:

The undersigned understands and agrees that the patient and guarantor are financially responsible to Buglisi Eye Care, PLLC, for charges for medically necessary services or services requested by or on behalf of the patient if such services are not covered by the patient's insurance plan or Medicare/Medicaid. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill, or is fully authorized as the patient's general agent to execute the above and accept its terms.

I HAVE READ, OR I HAVE HAD EACH OF THE ABOVE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

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Signature of Patient/Personal Representative	Name of Patient/Personal Representative	Date	D.O.B.