Leeds Family Eye Care, Inc.

Comprehensive Optometry
Jason B. Pulliam, O.D. and Richard T. Williams, O.D.

CONSENT FOR TREATMENT, RECEIPT OF PRIVACY PRACTICES, AND FINANCIAL AGREEMENT

PATIENT NAME: _____ DATE: _____

I consent to treatment necessary or desirable to the care of the patient mentioned above, including but not restricted to, dilation drops, pharmaceutical agents, and/or minor surgical procedures that may be used by the Doctor of Optometry, his technicians or qualified designate.

Dilation of the eyes is necessary to obtain the best view of your retina, but can cause blurred vision and/or glare for several hours. We recommend that you do not drive for the first few hours following dilation. You may return for this dilation on another date, use our phone to call someone to pick you up, or stay until the dilation effects have worn off. **I understand that if I choose to drive after dilation, I do so at my own risk, and Leeds Family Eye Care, Inc. will in no way be held responsible.**

I authorize the release of any medical information necessary to process a claim on any insurance that I am a member of. I authorize the release of all medical records on the patient listed above to the referring and family physicians, as well as to the following individual(s):

_____ _____

_____ _____

I hereby assign to and authorize the payment directly to Leeds Family Eye Care, Inc. for all benefits payable under such an insurance policy. I realize that the insurance benefits may not pay the entire bill, and **I agree to pay the difference or the entire bill if necessary. I will be responsible for paying all co-pays and/or deductible at the time of the visit.** In the event of default in the payment of my charges, I agree to pay all costs of collections, including a reasonable attorney's fee, should the account be referred to an attorney for collection.

I understand that some services are not always covered as dictated by my insurance company based on the medical necessity. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure, **I will be billed for those services.** I acknowledge as a member of these plans that this office will submit my insurance claim, and **I will be responsible for paying all copays and/or deductibles at the time of the visit.**

I authorize my insurance company to remit payment of medical benefits directly to this office for services provided.

I acknowledge that I received a copy of Leeds Family Eye Care, Inc.'s Notice of Privacy Practices.

Signature: _____ Relationship: _____ Date: _____

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Signature: _____ Relationship: _____ Date: _____

Signature: _____ Relationship: _____ Date: _____