HIPAA Consent Form

Authorization for Records Release & Acceptance of Financial Responsibility

I authorize the release of any information, including records of treatments and examinations, to people and locations that I choose over email, text, fax, and mail. This includes myself, my direct family members, doctors responsible for my health care, my pharmacy, and my insurance company.

I agree to pay the listed copayment or coinsurance for services I receive at Eyedentity. If I have no insurance, or if my insurance plan has no formal agreement with Eyedentity, I understand that I am responsible for my entire account balance when services and/or materials are delivered to me. If my insurance company denies or applies the claim submitted to my deductible, I will pay the balance on my account.

I understand that contact lens prescriptions are considered elective by most insurance companies and generally have an additional copay that must be paid before receiving my contact lens prescription. If I do not have insurance, I agree to pay the contact lens fitting/evaluation fee specified by Eyedentity. I understand that this payment does not include any contact lenses I may order in the future.

I hereby authorize and direct payment of my vision and medical insurance benefits to Eyedentity, Inc. for any services provided to me by Eyedentity. If I am on a Medicare Plan, I request payment of my Medicare benefits to Eyedentity for services provided by Eyedentity.

If I am in default of this agreement, I will pay all legal fees, court costs, & other costs necessary to collect the debt, including fees charged by a collection agency.

Signature_____ Date

Parent or Guardian's Signature _____

Patient's Name _____