POLARIS EYE CARE
PATIENT CONSENT AND FINANCIAL AGREEMENT

PATIENT NAME: _____ DOB: _____

_____ (initial)**1. CONSENT TO ROUTINE AND MEDICAL EYE CARE AND TREATMENT**
I request and authorize the doctors and employees of Polaris Eye Care to furnish routine vision care and/or medical eye care and related procedures that are in the best interest of my vision and/or eye health.

_____ (initial**) 2. HIPAA, PRIVACY PRACTICES & RELEASE OF MEDICAL RECORDS**
We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices. This notice includes information on how we may use information (records) regarding our treatment of your health conditions and related billing practices. I acknowledge that Polaris Eyecare has provided or made its privacy notice available to me.

_____ (initial) **3. PAYMENT GUARANTEE AND ASSIGNMENT OF BENEFITS**

- All co-pays (both medical and/or vision) are due at the time services are rendered.
- Payment in full is due prior to ordering any materials.
- All balances must be paid in full prior to receiving any materials.

For services and products and products rendered by Polaris Eye Care I guarantee payment for the account and agree to pay such account at the time services are rendered, if it will not be paid by my insurance carrier. I understand that the Payer may require authorization prior to my receiving treatment and that is my responsibility to obtain that prior authorization and know the coverage of my plan. I understand that receiving prior authorization does not guarantee that my payer will pay it, because the benefits permitted depend on my individual healthcare plan. I further understand that any out-of-pocket charges, co-payments, co-insurance, and deductibles will be my responsibility. If the amounts due to Polaris Eye Care for services rendered become delinquent and the debt is referred to an attorney or collections service, I understand and agree that Polaris Eye Care may recover from me all costs and expenses incurred in the collections effort, including any interest due. I acknowledge that if my child/dependent is cared for by Polaris Eye Care that I will be responsible for payment for services provided under these same terms and conditions. To the extent there is third party coverage of payment and services, I assign Polaris Eye Care all related benefits by payer on my behalf. I understand and agree that I may be required to pay a late fee if I do not pay in fill on the date services are rendered. I acknowledge that Polaris Eye Care has made their Patient Financial Policy available to me. I authorize the use of my signature below in all insurance submissions.

_____ (initial) **4. MEDICARE AGREEMENT (If Applicable)**
I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by Polaris Eye Care (or the party who accepts assignment), including services provided by the doctor. I authorize the release of any medical information about me to the Health Care Finance Administration and its agents, as well as any additional information needed to determine my benefits for related services.

I have read and understood all of the above and consent to it. I understand I may revoke this consent at any time but in doing so, or in refusing to sign, that I must pay for my services in full prior to treatment as my payer cannot be billed on my behalf without this signed consent.

Signature of Patient or Legal Guardian: _____Date: _____

Signature of Witness or Employee Initials: _____Date: _____

Polaris Eye Care | 1070 Polaris Parkway, Suite 110 | Columbus, OH 43240
J. Erin Shewring, OD | Jessica E. Lybarger, OD
Phone: 614-880-1493 | Fax: 614-880-9018