Millennium Eye Center

Patient's Name:	**Today's Date:** Click here to enter a date.
Patient DOB:	**Email:**

OFFICE POLICY CONSENT FORM

*Please **put a check mark** next to each applicable statement to acknowledge that you've received these notices, understand and agree with these policies. By selecting putting a check mark using any device, means or action, you consent to terms and conditions of this consent form. You further agree that your* **signature** *on this document (hereafter referred to as your "***E-Signature***") is as valid as if you signed the document in writing.*

☐ I have read ***The Pupil Dilation Information Form***, and **I consent** to pupil dilation.

☐ I have read ***The Pupil Dilation Information Form*** and **I DO NOT consent** to pupil dilation at my own risks. The doctor will not be held liable for any undetected medical and/or other eye conditions that may affect my vision as a result of my decision.

☐I certify I consent to ***The Lifetime Insurance Assignment*** to allow my insurance company to make payment for services rendered and that I am the patient and/or authorized as the patient's guardian or representative and have the authority to accept and execute the above terms and conditions.

☐ I certify I consent to ***Assignment Of Medicare & Medicaid Benefits.***

☐ I certify I consent to ***Patient Guarantor Agreement.***

☐ I further understand that there are **NO REFUNDS** and agree to the ***Refund Policy.***

☐ I understand that Millennium Eye Center reserves the right to charge a **$50 Missed Appointment** ("No-Show") **Fee.** This fee will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "No-Shows" in any 12 month period may result in termination from our practice.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICESS

The law requires that Millennium Eye Center, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

☐ I have read or had explained to me Millennium Eye Center, Inc.'s ***Notice of Privacy Practices*** and agree to continue my care with Millennium Eye Center, Inc. under said terms.

☐ I was given to opportunity to read Millennium Eye Center, Inc.'s ***Notice of Privacy Practices*** and declined but wish to continue my care with Millennium Eye Center, Inc. under the terms of Millennium Eye Center, Inc.'s ***Privacy Policies***.

☐ I have read or had explained to me Millennium Eye Center, Inc.'s ***Notice of Privacy Practices*** and do not wish to continue my care with Millennium Eye Center, Inc. under said terms.

☐ The ***Notice of Privacy Practices*** could not be read due to the emergent nature of the care

Millennium Eye Center

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize Millennium Eye Center, Inc. to release all eyewear orders and health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) to the following individuals:

Name: Relationship: Phone:

☐ I do not want my information to be released to anyone.

If you give us authorization to release your health information above, you may revoke it at any time by contacting in writing, FAX or email the **Privacy Official** noted in the ***Notice of Privacy Practices.***

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

☐ I have read and understand the statements on this form. I am signing it voluntarily.

Patient/Representative Signature Click here to enter a date. Date

For under age 18, a parent, guardian or representative must sign. If you are signing as a representative of the patient, please indicate your relationship.

Representative Printed Name Relationship to Patient

Your **signature** *on this document is as valid as if you signed the document in writing.*

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