Palos Verdes Family Vision Optometry, Inc.

Consent to Medical Treatment, Signature on File, Financial Agreement and HIPAA Notice of Privacy Practices

I consent and authorize Palos Verdes Family Vision Optometry and its agents to administer any treatment which may be reasonable or necessary for the diagnosis and treatment of myself or my family members.

Insurance Signature on File

Palos Verdes Family Vision Optometry is a provider for Medicare, but we do not accept assignment for Medicare or any other medical insurance plans. As a courtesy, we will file your insurance claim for any **medical office visit or examination**, but reimbursement will be directed to you. Routine, well vision examinations are not covered by any medical insurance. All fees must be paid at the time services are rendered.

I authorize Palos Verdes Family Vision Optometry (PVFV) to act as my agent in helping me to obtain payment of my insurance and/or Medicare benefits, and I request that these benefits be made either to me or on my behalf to PVFV for any services or materials furnished. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents, and to any other applicable health insurer, any information needed to determine these benefits payable for related services. My signature authorizes the release of the above medical information to the insurer or agency, and authorizes PVFV to act as my agent, as above.

Financial Responsibility

By signing this statement, I agree to be financially responsible for all charges, regardless of any third party coverage I may have. Professional fees are due when services are rendered and a 50% deposit is due when materials are ordered. Full payment is due at the time of dispensing of materials unless other arrangements have been made. Any check returned by the bank will incur a $25.00 charge. Overdue accounts may be referred to an outside agency for collection, and I will be responsible for all collection and attorney's fees.

HIPAA Acknowledgement

I acknowledge that I have been given the opportunity to review or receive PVFV Notice of Privacy Practices (9-13).

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Patient/Guardian Signature Date