UAB Eye Care

PATIENT:

AUTHORIZATIONS - PLEASE READ CAREFULLY

SERVICES AND FEES: I hereby consent to the examination and treatment that the provider feels is necessary for rendering good vision care. I understand that some services I receive at UAB Eye Care may be provided by qualified optometric interns in training, under the direct supervision of a fully degreed and licensed optometrist or other physician who will repeat key parts of the examination. I understand that the services I receive will only be performed when felt necessary and that some of these services may not be covered by my insurance. I understand I will be responsible for payment in full for all such services not covered by my insurance, that they may be considered lawful debt and promise to pay said fees including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state.

PERMISSION TO FILE INSURANCE CLAIMS AND FOR DIRECT PAYMENT OF INSURANCE BENEFITS: I authorize UAB Eye Care to file claims to my insurance provider on my behalf. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION FOR DIRECT PAYMENT OF INSURANCE BENEFITS: I authorize my insurance provider to make payments on my behalf directly to UAB Eye Care. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION TO RELEASE RECORDS TO OTHER HEALTHCARE PROVIDERS: I authorize UAB Eye Care to release records information regarding my care to other healthcare providers involved in my medical care. I understand I can revoke this authorization at any time by providing UAB Eye Care with a written statement indicating that I revoke this authorization.

PERMISSION TO USE ANONYMOUS MEDICAL INFORMATION IN HEALTHCARE TRAINING: I authorize UAB Eye Care to, when indicated, to make use of information from my medical records (including images of medical conditions) for the purposes of medical education. I understand that information used in this manner will not identify me by name and that I can revoke this authorization at any time by providing UAB Eye Care with a written statement stating such.

NOTICE OF PRIVACY PRACTICES (HIPAA): I understand that UAB School of Optometry and its affiliated clinics may share my health information for treatment, billing, and healthcare operations. I acknowledge that I have been given a copy of the UAB Eye Care Notice of Health Information Practices that describes how my health information is used and shared. I understand that UAB School of Optometry and its affiliated clinics have the right to change this notice at any time. I may obtain a current copy by contacting the UAB School of Optometry or any of its affiliated clinics.

My signature below constitutes my acknowledgment that I have been provided with a copy of the Notice of Health Information Practices.

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Signature of Patient (or Legal Representative) Date

If signed by legal representative, relationship to patient: _____