Cataract, Glaucoma & Retina
CONSULTANTS OF EAST TEXAS
Medical Arts Surgery Center | Benchmark Optical

TERMS and CONDITIONS

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement that you may send to your insurance company for payment. We will be happy to submit to most insurance carriers if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations: this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following procedures: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any person or organization without further authorization signed by me for release of the information.

TERMS AND CONDITIONS:

We respectfully request that all co-payments, deductibles and self-pay balances be paid at the time of your appointment. Customer agrees to pay a finance charge of one and one-half percent per month on all amounts due and owed to Cataract, Glaucoma & Retina Consultants of East Texas, if not paid at time of services.

ATTORNEY'S FEES AND COSTS:

If any legal action is necessary to enforce the terms of this Agreement, or if it is necessary to employ the services of an attorney to enforce the terms of the Agreement, the party in default or in breach hereof agrees to pay the other party's reasonable attorney's fees and court costs in addition to any other relief to which it may be entitled if Customer fails to pay any amounts owing hereunder when due, or otherwise breaches any terms of the Agreement. Customer agrees to pay up to 40% collection expense incurred by Cataract, Glaucoma & Retina Consultants of East Texas, in attempting to collect such amounts from Customer, in addition to aforementioned attorney's fees and cost.

SIGNED: _____ **DATE:** _____
Patient, Parent or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____ PHONE NUMBER(s): _____

RELATIONSHIP: _____ ADDRESS: _____

NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of Cataract, Glaucoma & Retina Consultants Of East Texas "Notice of Privacy Practices". This Notice describes how the companies may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____ Relationship to Patient: _____
Signature of Patient, or Personal Representative Date

Internal Use Only

If Patient/Patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (Date and Time): _____ By (Name and Title): _____

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