AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION*

I, _____(Patient name), *authorize* Miami Lakes Eye Care Center, to *release* or *discuss* information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named person(s)*

1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

****

* PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL **NOT BE GIVEN** ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.
* YOU ARE **NOT REQUIRED** TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

****

Please list any *additional* phone numbers where you would like us to contact you for:

* Reminder notices
* Changes on scheduled appointments

1. _____

2. _____

Patient Signature: _____

ACKNOWLEDGEMENT OF FEE

Form of payment for today's Services

Medical Insurance _____

Vision Insurance _____

Check One ( ) Cash ( ) Check ( ) Credit Card _____EXP _____

I understand there may be a separate Refraction Fee of $33.00 or Contact lens Fee for first time Fit of $70.00 and $35.00 for re-fit, for which my insurance may not cover.

Patient Name: _____ Date: _____

Signature: _____

I understand there is an added fee for returned checks and collections accounts.