

Ozark Retina & Macula

Springfield, MO 65804

Authorization to Release Information, Assignment of Benefits, and Consent for Treatment

1. **Release of information:** I authorize the disclosure of any or all of the information in my medical record to:
 - a. Any person, corporation, or agency responsible for all or part of Ozark Retina & Macula services who may be responsible for determining the necessity, appropriateness, payment, or other matters related to Ozark Retina & Macula treatment of services.
 - b. This includes, but is not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.
 - c. I further authorize Ozark Retina & Macula at its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier.
2. **Assignment of Benefits:** I assign to Ozark Retina & Macula the benefits due me covering Ozark Retina & Macula services, under my policy(s), managed care plan, HMO, or the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.
3. **Medicare Patients:** I authorize Ozark Retina & Macula to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.
4. **Financial Obligation for Ozark Retina & Macula:** I agree that I am financially responsible for payment of all amounts for services provided by the office and/or physicians. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between Ozark Retina & Macula and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO), I understand that I am financially responsible for non-covered services or deductibles, co-pay, or co-insurance as defined in my policy or plan. I also agree that if the account is placed for collection, I will pay all collection agency costs, and reasonable attorney fees. I agree to waive venue and do agree that any action filed to collect any amounts due for services rendered shall be filed in Greene County, Missouri. This includes patient's account balances and the collection of other expenses related to the patient's account balance such as service fees, court costs, and attorney fees.
5. **Guarantor's Responsibility:** I have read and understand the financial obligation above and agree to the terms as stated.

CONSENT FOR TREATMENT: As a patient of Ozark Retina & Macula, I agree, request, and authorize my attending physician to administer such treatment as is necessary. This includes their associates and/or assistants. Treatment may include such services, care, diagnostic procedures, and/or medical treatments, as the physician(s) deems reasonable and necessary.

AUTHORIZATION FOR DISCLOSURE: I give permission to discuss with the individual(s) I have listed:

Please check appropriate box (es)

- Any aspect of my health care Health information only Financial information only

I understand that I am responsible for notifying this office, in writing, or any changes to this authorization to disclose my personal health information.

Name _____ Relationship _____ Phone# _____
 Name _____ Relationship _____ Phone# _____
 Name _____ Relationship _____ Phone# _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM: The Notice of Privacy Practices of Ozark Retina & Macula sets forth the ways in which my personal health information may be used or disclosed and outlines my rights with respect to such information. I acknowledge that on ____/____/____,

- I received a copy of the Ozark Retina & Macula Notice of Privacy Practices
 I declined a copy of the Ozark Retina & Macula Notice of Privacy Practices

Patient Name (print) _____ Signature _____

(Patient or legal representative)

Date

Patient Date of Birth or SSN _____ Relationship if signed by other: _____