COREY H. TABBERT, OD
RICHARD A. PERROTT, OD
15 NE 5th Street
Grand Rapids, MN 55744

Thank you for choosing the **Eye Care Clinic** as your health care provider. We are committed to serving you and your eye care needs. The details of our office policies concerning Consent for Treatment, Privacy Practices and Account information are stated below. Please read these and sign below to begin treatment. This consent is effective indefinitely from the date you sign, unless you revoke it in writing.

CONSENT FOR TREATMENT
I, the undersigned, a patient (or her/his legal guardian) at this clinic do hereby authorize the doctors of the clinic to administer evaluation and treatment as indicated.

NOTICE OF PRIVACY PRACTICES
The law requires that the Eye Care Clinic makes every effort to inform you of your rights related to your personal health information.
By signing below you are acknowledging that you have read or had the opportunity to read or have explained to you the Eye Care Clinic's Notice of Privacy Practice and agree to continue your care under said terms.
If you choose not to sign, we reserve the right to refuse care except in the case of an emergency.

ACCOUNT AND CREDIT INFORMATION
Assignment of Benefits
I understand and agree that health insurance policies are an agreement between an insurance carrier and me. I understand that some insurance companies require medical or administrative pre-authorization for visits. I understand I am responsible for knowing and meeting the requirements of my insurance plan. Furthermore, I understand that as a courtesy, the office will prepare insurance forms and bill my insurance company directly. I authorize the office to release medical or other information necessary to process this claim. I hereby request assignment of payment of all insurance benefits to this office. I also understand that I am ultimately responsible for payment of all services rendered, unless otherwise provided by law. Prompt payment of your bill is considered part of your treatment.

PATIENTS WITH INSURANCE COVERAGE
We accept assignment for most insurance coverage. However, we do require your co-payment be paid at the time of service. Any balance incurred is your personal responsibility even though you have insurance coverage. Coverage amounts vary from policy to policy and we cannot guarantee the amounts of coverage offered by your insurance carrier. It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. You understand that your insurance policy is a contract between you and your insurance company. This office holds no part to that contract and will not be held responsible in the event your insurance company denies any part of your claim.

PAYMENT OF ACCOUNT
PAYMENT IS DUE AT THE TIME OF SERVICE
For your convenience, we accept cash, checks, Visa, Master, American Express or Discover Card.
A finance charge of 18% annually (1.5% per month) will begin accruing 60 days from the date of service.

DELINQUENCY
In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection cost (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by this office.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient or Legal Guardian's Signature Date

I ALSO GIVE CONSENT TO HAVE MY INFORMATION RELEASED TO THE FOLLOWING PERSON(S):

Name: _____ Relationship to Patient: _____