VISION SOURCE®
SIGNATURE EYE CARE

PATIENT CONSENT AND WAIVER FORM

_____ **Permission to bill my Vision/Medical Insurance Plan Directly:**
I authorize my insurance company to release payment directly to Vision Source Coral Springs or its doctor, Dr. Katherine Orellana-Medina. I understand that I am financially responsible for any charges not covered by my vision or medical insurance.

_____ **Release of my Patient and Health Information to my Vision/Medical Insurance Plan:**
I authorize Vision Source Coral Springs to provide my insurance company with any information in my medical record. The notice of Privacy Practices is available to be read in the waiting room and I have had the opportunity to read and consider the contents of this consent form. I understand that by initialing this form, I consent to the use and disclosure of my protected information to carry out treatment, payment activities, and healthcare operations.

_____ **Medicare and Medigap Lifetime Signature Authorization:**
I authorize Vision Source Coral Springs to release to the Social Security Administration or the Healthcare Financing Administration any information needed for this Medicare Claim. I request that payment of medical Insurance benefits be made on my behalf to Vision Source Coral Springs for any service furnished to me by the doctor or her associates. I understand that I am responsible for any health deductibles and coinsurance payments.

_____ **Consent for Pupil Dilation ____ YES ____ NO**
Pupil dilation is the use of eye drops to enlarge the pupils to check the health of the eye internally looking for any ocular diseases that would otherwise go undiagnosed. Dilation is a required component of your yearly exam, especially necessary if you are diabetic, are hypertensive, or experiencing severe headaches, or new vision loss. In children, dilation may be necessary to determine if glasses are needed. Side effects are typically mild and include blurry near vision and sensitivity to sunlight that lasts around 2-4 hours. Most patients can drive afterwards, BUT you are responsible to arrange transportation if you do not feel safe driving. Dilation is included in a yearly eye exam and it may be rescheduled for up to a month. I understand the low risk associated with dilation and I will reschedule if I do not feel comfortable driving home.

_____ **I understand that I am responsible for all fees, co-payments, deductibles and non-covered services if NOT paid by my Vision/Medical Insurance Plan. There is a $50 service charge if my personal check is returned due to insufficient funds. If my account becomes delinquent in payment, I agree to pay all costs related to a collection agency including reasonable attorney fees. I also agree to a $25 no show fee, if I fail to cancel any future appointments within 24 hours of that exam.**

1._____ _____

2._____ _____

3._____ _____

_____ **4.**_____ _____ _____

Date Patient Name(s) Signature(adults 18+) Parent/Guardian Name