Dr. Steven Bovio
Dr. Cameron Jones
Board Certified Optometric Physicians

TREATMENT CONSENT, PATIENT RESPONSIBILITIES & INFORMATION RELEASE AUTHORIZATION

I give permission to Gulfcoast Eye Center to provide medical treatment for me.

I allow Gulfcoast Eye Center to file for insurance benefits to pay for the care received. Gulfcoast Eye Center may send medical information to my insurance company and their subsidiaries.

Assignment of benefits will be made from my insurance companies to Gulfcoast Eye Center.

I must pay for my share of costs including deductibles, copayments, refraction fees, and any non-covered services.

I must pay the entire cost of services if active insurance coverage is not in place or if the insurance company does not pay.

I understand that payment is due at the time services are rendered.

NOTICE OF PRIVACY PRACTICES: I have received a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand Gulfcoast Eye Center may change this notice at any time. I may obtain a current copy of the privacy notice by contacting Gulfcoast Eye Center.

I understand and agree to all of the above:

Patient/Parent/Legal Guardian Print Name_____

Date: ____/____/_____

Patient/Parent/Legal Guardian Signature

_____

If the patient is a minor (under the age of 18) or not legally responsible, please state:

Responsible Party: (Print Name) _____

Relationship to Patient: _____

Responsible Party's Date of Birth: ____/_____/_____

Address of responsible Party:

_____

City_____ State_____ Zip _____