

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND  
PATIENT AGREEMENTS RELATED TO TREATMENT**

**CONSENT FOR ROUTINE MEDICAL TREATMENT**

Pediatric Ophthalmology, Inc. d/b/a Pediatric Eye Associates and its employees are hereby authorized to collect medical history information, obtain vital signs and perform other routine procedures for purposes of providing care to you. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

**CONSENT TO DISCLOSURE OF INFORMATION**

Patient medical records and billing information are created and retained by Pediatric Eye Associates and are accessible to its personnel and medical staff for use in my care. Pediatric Eye Associates personnel and physicians may use and disclose medical information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. Pediatric Eye Associates is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of Pediatric Eye Associates charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. Oklahoma law requires that we advise you that the **information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS).** By signing this agreement you are consenting to such disclosure. You may revoke this consent in writing addressed to Pediatric Eye Associates, except to the extent we have already acted in reliance on it.

**ASSIGNMENT OF INSURANCE BENEFITS**

You agree that insurance benefits for Pediatric Eye Associates charges payable to the insured are to be made payable to Pediatric Eye Associates and that insurance benefits for services provided by physicians in the hospital setting otherwise payable to the insured are to be made payable to the physician(s) responsible for your care. Any payment received for this episode of care may be applied to any unpaid bills for which you are liable subject to the rules of coordination of benefits.

**PRECERTIFICATION POLICY**

You understand that Pediatric Eye Associates will assist with insurance precertification requirements which are the responsibility of the policyholder and/or hospital, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

**FINANCIAL RESPONSIBILITY**

As consideration for the services provided to you, payment is guaranteed for any amount due for such services provided by Pediatric Eye Associates. Charges for services and goods shall be at Pediatric Eye Associates billed charges rates unless otherwise agreed to in writing by Pediatric Eye Associates.

**PATIENT'S CERTIFICATION**

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or legally authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

\_\_\_\_\_  
Signature of Patient / Parent / Legally Authorized Representative (Documentation must be provided)

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

A complete description of how your medical information will be used and disclosed by Pediatric Eye Associates is in our **NOTICE OF PRIVACY PRACTICES**, which you should read before signing this Acknowledgment. The Notice is posted throughout our office and you will be given a copy for your personal use.

I have received a copy of Pediatric Eye Associates Notice of Privacy Practices dated April 14, 2003.

\_\_\_\_\_  
Patient / Parent / Legal Representative

\_\_\_\_\_  
Legal Authority of Representative

\_\_\_\_\_  
Date Signed

Basis for refusal, if refused: \_\_\_\_\_